HOSPITAL Topics

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JUNE | 1957

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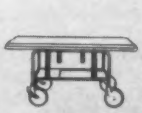

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HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICE

JUNE 1957, VOL. 35, NO.

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PERSONALITY OF THE MONTH

ELLEN P. YOUNG, R.N., executive director, Memorial Hospital, Albany, N. Y., has held that position since 1941. During 1940-41 she was director of nurses at the hospital. At present a new 235-bed hospital (with 40 bassinets) is being constructed on a new site and is scheduled to open early in September.

After graduating from the Quincy (Mass.) City Hospital school of nursing, she became a nursing arts instructor there for two years, but in 1931 accepted a position as director of nurses and science instructor, Memorial Hospital, Nashua, N. H., where she remained until 1939.

She found time to obtain a B.S. degree from Teachers' College, Columbia University, in 1940.

Miss Young is a member of the New York State Nurses' Association, American Nurses' Association, and the National League for Nursing. She also belongs to both the New York State Hospital Association and the American Hospital Association. She is a past president, Northeastern New York Hospital Association.

The Zonta Club, composed of executive women in business and professions, also claims her as a member. This organization admits only one woman in each executive capacity, so Miss Young is the only executive director of a hospital on its roster.

Miss Young devotes some of her spare time to making ceramics, and to her other hobby, weaving. She is an active member of the Troy and Albany Craft Guilds.

COMING NEXT MONTH

Reports on:

American Medical Association

Catholic Hospital Association

American Psychiatric Association

Upper Midwest Hospital Conference

Texas Hospital Association

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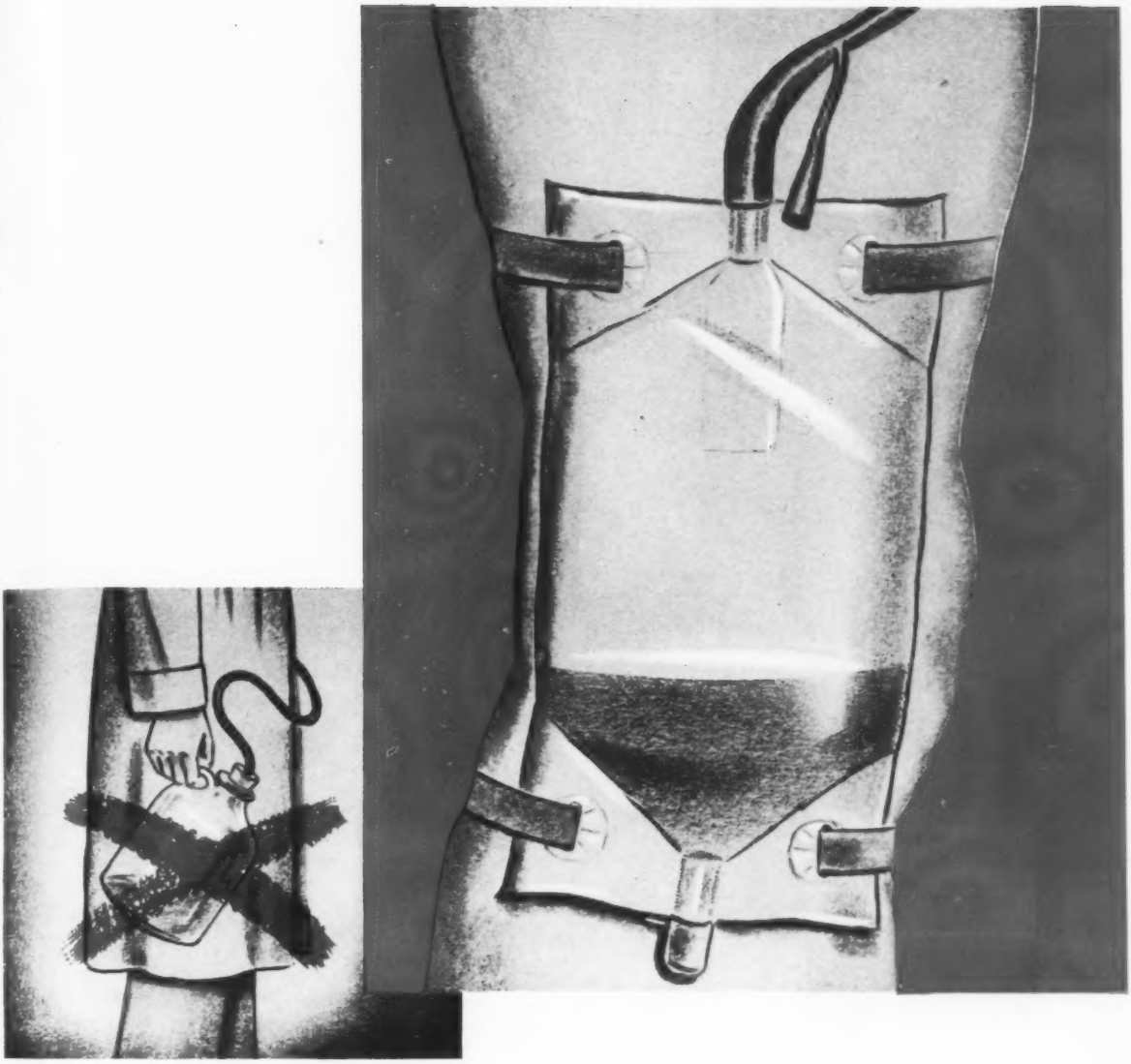

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HOSPITAL Topics
The News Magazine for the Hospital Staff

JUNE, 1957
VOL. 35, NO. 6

Scanning the News

Use of TB Drug Stimulates Depressed Mental Patient

Good results have been achieved in treatment of mental patients with iproniazid, an iso-nicotinic acid compound, originally used as an anti-tuberculosis drug, according to Nathan S. Kline, M.D., director of a five-month study project at Rockland State Hospital, Orangeburg, N.Y.

Of 17 chronic hospital patients studied, 47 percent showed improvement within five weeks, and 70 percent after the five-month period. Most were schizophrenics, and two of the best responses came from generally non-responsive regressive patients.

Dr. Kline describes the drug's action as a "psychic energizer," in direct contrast to action of tranquilizing drugs.

Corroborative evidence of effective use of the drug was made by two other research groups, working independently. George E. Crane, M.D., Montefiore Hospital, New York City, cited 75 percent effectiveness in a group of 20 tubercular patients studied, 13 of whom were mildly or seriously depressed.

Arthur L. Scherbel, M.D., director, department of rheumatic disease, Cleveland (O.) Clinic, reported good results on a five-year study with rheumatoid arthritis patients who had become depressed, dependent, and hostile in varying degrees as a result of having arthritis.

Plantar Warts Respond To X-ray Treatment

Plantar warts, occurring most often on the ball of the foot, can be treated painlessly by x-rays, reports Robert J. Reeves, M.D., in the November, 1956 issue, *The American Journal of Roentgenology, Radium Therapy and Nuclear Medicine.*

In one series of 208 patients, there were excellent results in 98 percent.

Dr. Reeves, radiologist, Duke University Medical School, Durham, N.C., said the incidence of these warts has appeared to increase in recent years, possibly due to increasing popularity of sports and the frequent use of public shower baths and locker rooms.

He cautioned against retreating the area with irradiation if it should fail.

Watching a demonstration of shock treatment are several of the ministers, priests, and rabbis invited to visit Cleveland Receiving Hospital and its affiliate, the State Institute of Psychiatry, during Mental Health Week. Left to right are: the Rev. D. J. Chipka, Corlett Avenue Baptist Church, Cleveland; the Rev. Valerius Messerich, Our Lady of Angels Friary, Cleveland; the Rev. S. E. Nachtigall, Church of God, Cleveland; Betty Sikula, R.N.; John Mezkalnins, M.D., psychiatrist, and student nurse Patricia Smith. The clergy saw patients in their wards; watched them at various vocational pursuits; saw the latest equipment demonstrated in laboratories, and heard psychiatrists discuss use of tranquilizing drugs. James Carson, M.D., chief psychiatrist in the men's ward, talked on "Psychiatric Care of the Patient," and Ira Friedman, M.D., director, psychology department, described the testing program. Esther Wagner, director of social service, gave a report on "Hospital Case Work."

Link Epilepsy to Faulty Brain Chemistry

Epilepsy has been linked to faulty brain chemistry, according to Donald B. Tower, M.D., National Institute of Neurological Disease and Blindness, National Institutes of Health, Bethesda, Md.

Substances which are altered in epileptic brain tissue are glutamic acid, an amino acid making possible many other chemical reactions in the brain; acetylcholine, a chemical transmitter of nerve impulses, and potassium, which helps nerve cells conduct impulses along their fibers.

Partial proof of the biochemical basis of epilepsy has been shown by results of treatment with asparagine, a chemical that steps up production of glutamic acid. The drug helped reduce seizures in a small group, but also produced bad side effects.

Baby Atom Smasher Treats Deep-Seated Cancer

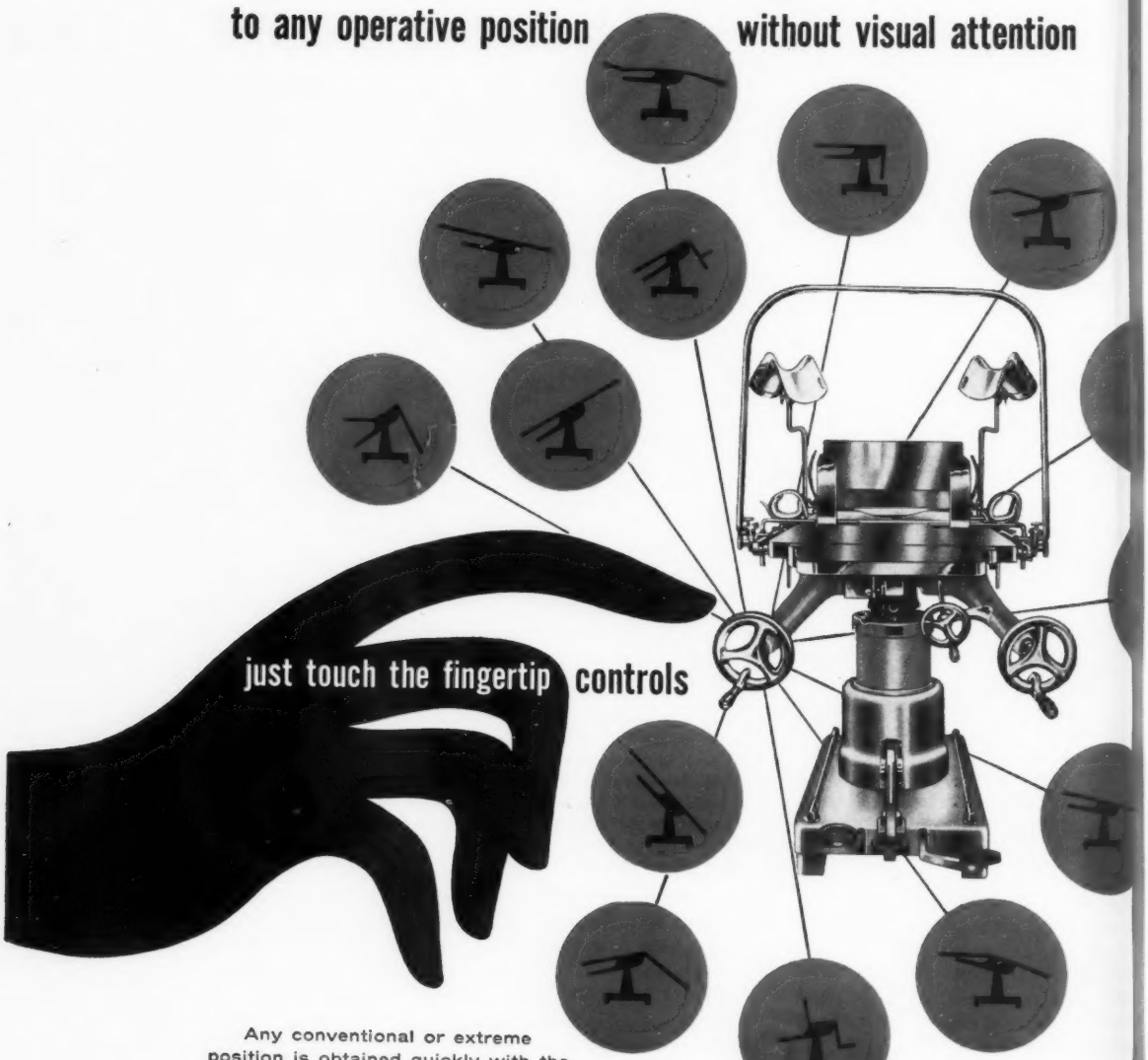
Tumors have disappeared in 48 of 74 patients treated with a six-million volt linear electron accelerator.

Radiologists Malcolm A. Bagshaw, M.D., and Henry S. Kaplan, M.D., Stanford University School of Medi-

(Continued on page 14)

shift quickly

to any operative position without visual attention



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At Press Time

Chicago, May 18, AHA Dues Increase Approved; Revolt Averted

In a meeting with a minimum amount of fireworks, AHA delegates voted, 65-15, to increase dues 50 percent for the years 1957-1960 inclusive, to enable the association to construct a headquarters building of 12 stories instead of the originally planned 17.

The 12-story building proposal was evolved at a board of trustees' session the night before the delegates' meeting. When delegates convened, board members were ready with several recommendations, all of which were approved in a little less than three hours, with only a few hints of revolt. The proposal for 12 stories caught off guard some of the delegates who had been instructed to vote "no" on a 17-story building, but weren't quite sure whether they should oppose 12 stories.

Besides approving the 50 percent increase, delegates voted also:

• To defer consideration of a fund-raising campaign until the 1957 meeting, after AHA President Albert W. Snoke advised them that there is a lack of knowledge among the nation's industrial leaders about AHA activities, and that an educational campaign is necessary.

• To change the wording in the bylaws from "special assessment" to "temporary dues increase," thus clarifying legal terminology and also removing any barrier to participation by government hospitals, in many of which special assessments are prohibited.

• To exclude from the four-year increase personal members and Type 5 (women's auxiliaries) and Type 6 (hospitals under construction, foreign hospitals, and allied health organizations).

• To give the AHA authority to bill hospitals directly rather than through the state associations. (If billing were done through the associations, they would get 10 percent of the money collected.)

A rumored "Western revolt" did not materialize. California delegate George U. Wood read a resolution from his state asking for a six-story building—but he voted "yes." The warmest objections were registered by Alabama delegate John L. Howell and Pennsylvania delegate Charles S. Paxson, Jr.

Mr. Howell seemed to threaten Southern secession when he said, "We seem to be building only a monument. Have there been inexcusable errors of judgment (regarding the revision of costs)? Our vote in the affirmative is not for the present building committee. Many Alabama hospitals believe they are a captive audience and question continuing membership. Our vote in the affirmative is to continue the services of the AHA, but we question the leadership and the board of trustees of the association."

After delivering his kicks in the teeth, Delegate Howell gave the AHA some pats on the back for its invaluable services to members—and he voted "yes."

Of 220 Pennsylvania hospitals, said Delegate Paxson, only 15 percent have agreed to go along with the 50 percent dues increase. Sixty percent are unalterably opposed. Thirty-three hospitals have threatened to withdraw from the AHA, and 25 are considering withdrawal, he said. Pennsylvania's three delegates later voted "no."

Florida delegate Pat Groner asked for a unanimous decision for "whatever is necessary" and to endorse AHA leadership. The pendulum began to swing then to the affirmative side when Oklahoma's Kenneth Wallace said, "Oklahoma is happy to pay its dues." A New York delegate said he was disappointed to learn that the board was backing down on the 17-story building, but that the New York State Hospital Association was willing to contribute $10,000 to the building fund.

Would it be possible to make the dues increase less than 50 percent because of the smaller building, Utah delegate John Zenger wanted to know. Dr. Snoke's answer: No.

Henry Hill of Colorado and Edward Horgen of Kentucky announced they had been instructed to vote against the increase—but Mr. Hill said that he personally favored it.

George F. Pendergraft of Montana, in voting no, said that his state was one of small hospitals which could not afford increased dues. Other states voting no, besides Colorado, Kentucky, and Montana, were Maine, New Hampshire, New Jersey (two votes), Nebraska, Pennsylvania (three votes), Virginia, West Virginia, Wyoming, and Alberta. Three delegates abstained from voting—Reginald H. Dabney, Maryland Hospital Service, and Paul A. Webb, Associated Hospital Service of Maine, both Type IV delegates, and S. V. Pryce of Alberta.

Delegates from Alberta, Manitoba and Quebec asked for special consideration, pointing out that Canadian hospitals do not have the benefits of Hill-Burton funds nor of grants from the Ford Foundation. The Quebec delegate warned that he expects a 55 percent drop in membership in his province.

As the meeting came to a close, Oklahoma delegate Wallace presented a resolution stating that the House of Delegates "views with alarm" the tendency of some members threatening to withdraw their support. He called for a vote of complete confidence in the honesty and integrity of AHA officers and trustees.

The "move-in" costs of a 12-story building will be $7,851,900. This figure is not to be confused with the estimated *construction* cost of $7,800,000 quoted last summer for a 17-story building when the AHA announced that there had been a $3,000,000 increase over the original cost estimates. *Construction* cost for the 12-story building is estimated at $6,900,000.

Now, AHA President Snoke told delegates, a 17-story building would require more than $5 million additional in construction, which would leave no appreciable reserves. Also, the AHA could not borrow the money needed and finance the program properly.

Costs of the 12-story building, Dr. Snoke said, could be met by an additional $1,150,000 bank loan which could be repaid by 1960 with funds received from the temporary dues increase. The bank has approved such a loan, provided that the association can show projected income from the dues increase and from an annual rental income of $120,000 from the four extra floors set aside for rental to allied organizations (the AHA has almost met this figure), and 90 percent of the membership income will be assured.

Gordon M. Marshall

Calendar of Meetings

JUNE

3- 7 American Medical Association, Hotel Waldorf-Astoria and Coliseum, New York City

3- 7 International Hospital Congress, International Hospital Federation, Hospital de Santa Maria, Lisbon, Portugal

3- 7 American College of Hospital Administrators Basic Institute (Midwestern), Colorado Women's College, Denver, Colo.

10-14 American College of Hospital Administrators Conference, Region 13, University of California, San Francisco

11-12 Maine Hospital Association, Somerset Hotel, Rockland, Me.

17-21 American Hospital Association Institute, Nursing Service Administration, Chateau Laurier, Ottawa, Can.

21-22 Michigan Hospital Association, Grand Hotel, Mackinac Island

22-29 American Society of Medical Technologists, Palmer House, Chicago

23-29 American Physical Therapy Association, Hotel Statler, Detroit, Mich.

24-26 Comite des Hospitaux du Quebec, Montreal Show Mart

24-28 American Hospital Association Institute, Hospital Pharmacy, University of Washington, Seattle

24-28 American Hospital Association Institute, Developing Skills of Supervision, Edgewater Beach Hotel, Chicago

JULY

8-12 American Committee on Maternal Welfare, Palmer House, Chicago

15-19 American Osteopathic Association, Adolphus Hotel, Dallas, Tex.

15-20 International Congress of Clinical Pathology, Brussels, Belgium

AUGUST

1- 3 West Virginia Hospital Association, Greenbrier Hotel, White Sulphur Springs, W. Va.

5 American Hospital Association Institute, Dietary Dept. Administration, Ambassador Hotel, Los Angeles

19-23 American Hospital Association Institute, Hospital Pharmacy, University of Chicago, Chicago

23-27 American Surgical Trade Association, Hotel Sherman, Chicago

SEPTEMBER

3-13 American College of Hospital Administrators Basic Institute, International House, Chicago

8-13 American Congress of Physical Medicine and Rehabilitation, Los Angeles, Calif.

9-13 American College of Hospital Administrators Advanced Institute, International House, Chicago

16-26 Workshop on Aseptic Technic, University of Minnesota Center for Continuation Study, Minneapolis.

28-30 American College of Hospital Administrators, Atlantic City, N. J.

29-Oct. 4 American Society of Clinical Pathologists, Roosevelt Hotel, New Orleans, La.

30-Oct. 3 American Hospital Association, Hotel Traymore, Atlantic City, N. J.

OCTOBER

7-10 American Academy of Pediatrics, Palmer House, Chicago

7-10 American Hospital Association Institute, Operating Room Administration, President Hotel, Kansas City, Mo.

7-10 American Association of Medical Record Librarians, Schroeder Hotel, Milwaukee, Wis.

(Continued on page 13)

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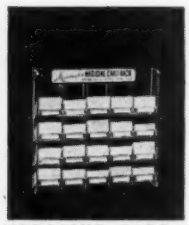

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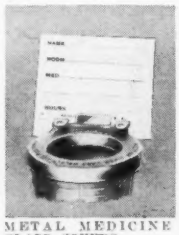

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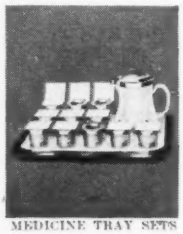

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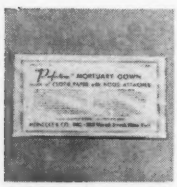

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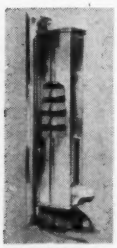

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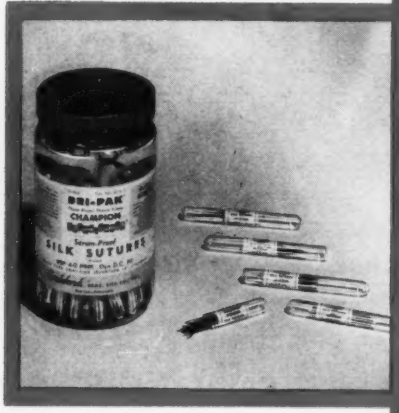

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CALENDAR (Con

9-10 Indian Hospit ing, I.

9-10 Washi tion, Wash.

9-11 Missis Hotel

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27-31 Ame Surg Mo.

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JUNE,

CALENDAR OF MEETINGS

(Continued from page 10)

9-10 Indiana Hospital Association, County Hospital Section, Student Union Building, I.U. Medical Center, Indianapolis

9-10 Washington State Hospital Association, Leopold Hotel, Bellingham, Wash.

9-11 Mississippi Hospital Association, Hotel Buena Vista, Biloxi, Miss.

13-18 American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago

14-18 American Society of Anesthesiologists, Statler Hotel, Los Angeles

14-18 American College of Surgeons Clinical Congress, Convention Hall, Atlantic City, N. J.

15-16 South Dakota Hospital Association, Sheraton Cataract Hotel, Sioux Falls, S. D.

20-26 American College of Gastroenterology, Hotel Somerset, Boston

21-23 American Hospital Association Institute, Medical Record Library Personnel, Hilton Hotel, Albuquerque, N.M.

21-25 National Safety Council, Conrad Hilton Hotel, Chicago

22-25 American Dietetic Association, Dinner Key Auditorium, Miami, Fla.

26 American College of Osteopathic Hospital Administrators, St. Louis, Mo.

26-30 American Heart Association, Sherman Hotel, Chicago

27-30 Association of Military Surgeons of the U. S., Hotel Statler, Washington, D. C.

27-30 American Osteopathic Hospital Association, St. Louis, Mo.

27-31 American College of Osteopathic Surgeons, Jefferson Hotel, St. Louis, Mo.

NOVEMBER

3- 6 American Association of Blood Banks, Chicago

5- 7 American Association of Inhalation Therapists, Cleveland, O.

11 American Hospital Association Institute, Housekeeping, King Edward Hotel, Toronto, Can.

11 American Hospital Association Institute, Medical Record Library Personnel, Sheraton-Plaza Hotel, Boston, Mass.

11 American Hospital Association Institute, Nursing Service Administration, Princess Kaiulani Hotel, Honolulu, Hawaii

11-15 American Public Health Association, Auditorium, Cleveland, O.

14-15 American Hospital Association Institute, Operating Problems in Small Hospitals, The Bessborough Hotel, Saskatoon, Can.

14-22 Pan-Pacific Surgical Association, Honolulu, Hawaii

17-22 Radiological Society of North America, Palmer House, Chicago

18-20 Maryland-D.C.-Delaware Hospital Association, Shoreham Hotel, Washington, D. C.

18-22 Pan American Medical Association, Mexico City, Mexico

18-22 American College of Hospital Administrators, New England Institute, Somerset Hotel, Boston

DECEMBER

2- 6 American College of Hospital Administrators, Advanced Institute, Ambassador Hotel, Los Angeles

3- 6 American Medical Association (Clinical Meeting), Commercial Museum, Philadelphia

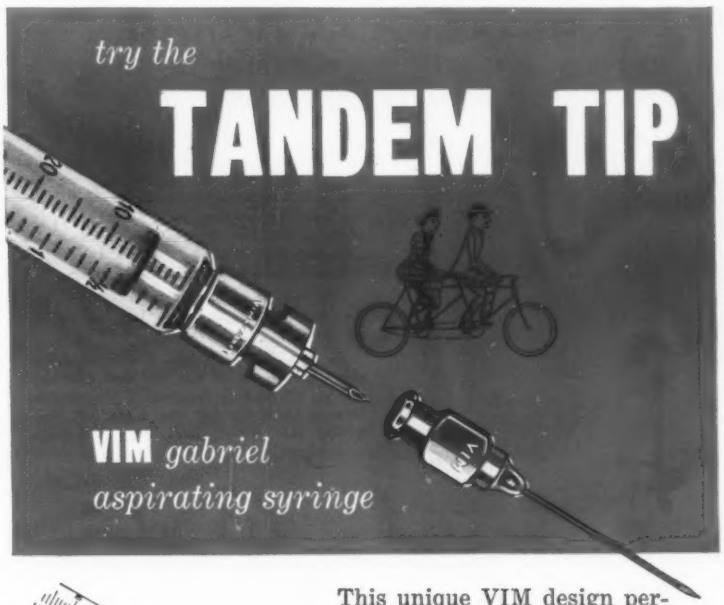
7-12 American Academy of Dermatology and Syphilology, Palmer House, Chicago

26-31 American Association for Advancement of Science, Murat Temple, Indianapolis, Ind.

FEBRUARY 1958

9-12 Association of Operating Room Nurses, Bellevue-Stratford Hotel, Philadelphia

11-13 National Association of Methodist Hospitals and Homes, Morrison Hotel, Chicago



Sturdy, large gauge permanent aspirating tip pierces toughest vial diaphragm, withdraws solution easily.

A quick twist locks injecting needle on aspirating tip. Either VIM Stainless or VIM Laminex needles may be used.

This unique VIM design permits easy, complete withdrawal of even the most viscous solution — ends bending, breaking, dulling of hypodermic needles because only aspirating tip pierces vials' rubber seal — greatly increases needle life.

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Gabriel Aspirating Syringe

Available through your surgical/hospital supply dealer or write: MacGregor Instrument Co., Needham, Mass.

(Continued from page 7)

cine, San Francisco and Stanford, reported that tumors disappeared in five other patients, but cancer had already spread to other parts of the body. The treatment failed to help in 21 cases.

Designed and built under direction of Edward Ginzton, M.D., director, Microwave Laboratory and Dr. Kaplan, head, radiology department, the machine's principal advantage is its high energy.

The 6,000,000 volt x-rays deliver a deeper-level maximum dose than conventional 200-300,000 volt x-rays, minimizing damage to skin surfaces.

The high-energy beam penetrates bone, fat, and other tissues with equal ease, eliminating "bone shadows" and simplifying treatment in such areas as jaw or pelvis.

Throat, lung, prostate, kidney, bladder, bone and brain tumors were included in the report of the accelerator's first year of therapy.

Of the 21 patients the accelerator failed to help, eight had been treated earlier with conventional x-rays. Results of using the accelerator to treat such patients have been encouraging, Dr. Bagshaw said.

Three others in the "failure" group also previously treated with conventional x-rays, were given only a small palliative dose from the accelerator.

Three patients were counted "failures" because they have not been available for follow-up reports, leaving seven patients for whom there is definite evidence that the accelerator could not control tumor growth.

The project has been aided by grants from the American Cancer Society, National Cancer Institute of the U.S. Public Health Service, and James Irvine Foundation of San Francisco.

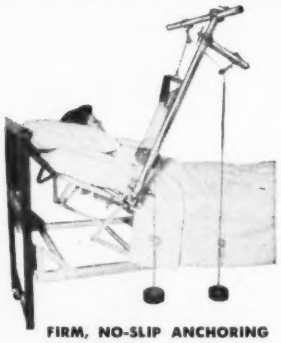
the new **ZIMMER**

OCTAGON ALUMINUM SIDE ARM TRACTION FRAME NO. 908

Attaching simply to the springs of the bed, the new Side Arm Traction Frame eliminates the need of keeping the patient stationary while in traction. With this new frame the back rest of the bed can be raised or lowered, yet the traction remains unchanged.

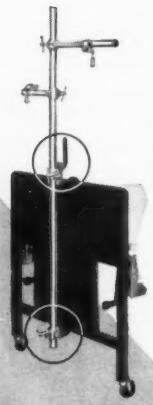
This new frame may also be fastened near the end of the bed for traction on the leg or foot.

As this Side Arm Frame is assembled from component parts of our No. 640 Overhead Frame, all that is required if the hospital already has a No. 640 and a No. 641 frame is one No. 908-01 Base Clamp Assembly.



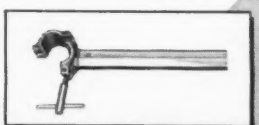
NO. 908 SIDE ARM TRACTION ASSEMBLY CONSISTS OF:

1 908-1 Base Clamp Assembly
1 908-03 27" Traction Arm
(1 640-3B 27" Traction Arm may be used)
1 640-3A 36" Traction Arm
1 640-3D 9" Traction Arm
3 640-4 Pulley & Clamp Assembly
(No cords or weights furnished)



FIRM, NO-SLIP ANCHORING

The octagon clamp provides firm anchorage of cross arms without marring tubing.



⇦ TOGGLE CLAMPS as used with the complete 640A Octagon Aluminum overhead frame.

zimmer

LOOK FOR THE TRADEMARK

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In Canada Available through selected surgical supply dealers or through our Agents, Fisher & Burpe, Ltd.

Study Amine Acid as Alcoholic Cure

A natural amine acid, glutamine, reportedly helps reduce craving in some chronic alcoholics, according to William Shiva, Ph.D., professor of chemistry, University of Texas, and research workers at its Biochemical Institute.

Glutamine, a protein building block, may nourish an impaired brain center that ordinarily controls craving for alcohol, he suggested in a report to the American Chemical Society in Miami, Fla.

The scientist reported test results on 40 alcoholics fed doses of glutamine. "In 20 patients, alcoholism was controlled, even showed improvement; there was no change in six and three were worse," he said.

Alcohol might inhibit production and use of glutamine for some biological process in alcoholics, Dr. Shiva suggested.

He reported evidence suggesting that ulcers in some heavy drinkers might result from inhibition of the use of glutamine in making proteins needed by the stomach lining.

Animal Research Bill Signed in Massachusetts

A bill providing for the use of stray animals in medical research has been signed by Massachusetts' Gov. Foster Furcolo.

Stray animals from public pounds may be used by medical schools and research hospitals if not claimed with 10 days.

Antivivisectionists, who had successfully opposed similar bills in the past, are expected to challenge the constitutionality of the new law.

WESCODYNE® cleans as it disinfects

for less than two cents a gallon

FOR ALL AREAS

WESCODYNE is a completely new detergent-germicide that contains amazing "Tamed Iodine"®. Increases germicidal capacity three to four times and offers a much wider range of effectiveness than solutions containing chlorine, cresylics, phenolics or quaternaries.

WESCODYNE is also an excellent detergent as well as a powerful disinfectant. Provides fast cleaning action as it disinfects. A time and labor saver.

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WESCODYNE is recommended for almost any disinfecting procedure. Safe to use. Unaffected by hard or cold water. Leaves no "hospital smell." Send coupon for full information, including recommended surgical, nursing and hospital procedures.

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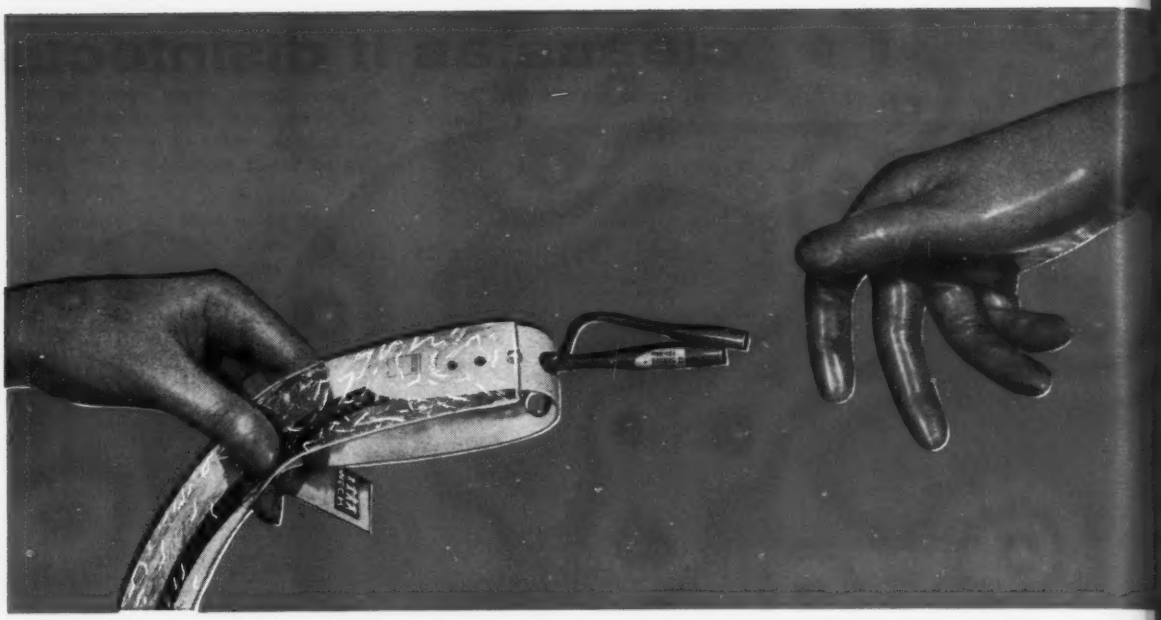
☐ Please send full information on Wescodyne.
☐ Please have a West representative telephone for an appointment.

Name .....

Position .....

Mail this coupon with your letterhead to Dept. 40



In sterilizing catheters, a special perforated paper tongue, which holds the catheter, also serves as a means of removing it without contamination. As illustrated, the nurse, after partly withdrawing the catheter, holds the unit, with paper tongue folded between her fingers, while the surgeon's gloved hand removes the catheter.

The 11,564,227th Catheter

STERILIZED IN

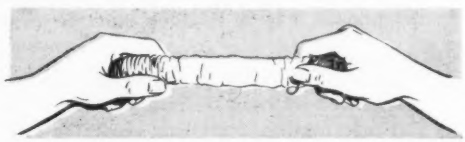
WECK Sterilizing Tubing

Seems pretty fantastic? Yet, figuring the total number of feet of Weck Tubing sold (as of April 1, 1957) and the percentage used for sterilizing catheters, we arrive at the amazing figure shown above.

What was a novelty only five years ago—the use of cellophane in cylindrical form for packaging various articles for sterilizing—is now prescribed as standard procedure in the leading hospitals of America.

In addition to smaller articles such as catheters*, needles, syringes, rectal tubes, drains, etc., Weck Sterilizing Tubing *in the new larger sizes* accommodates many sets and kits such as suture removal sets, complete suture sets, post-operative dressing sets and instruments of all sizes up to obstetric forceps.

Write for reprint of hospital magazine article giving additional information on the use of Weck Sterilizing Tubing—including price list.



Weck Sterilizing Tubing comes in compressed, easy-to-open cylindrical "sticks" in these sizes: 1 1/16", 2 5/16", 3 7/8".

Recommended by C. R. Bard, Inc. for the sterilizing and storing of their catheters.

67 years of knowing how

EDWARD WECK & CO., INC. 135 Johnson St., Brooklyn 1, N. Y.

Manufacturers of Surgical Instruments • Hospital Supplies • Instrument Repairing

Hill-Rom No. 42—No. 43 Recovery Beds

No. 42 RECOVERY BED. Head and footboard panels are wood with stainless steel protective strips. Both ends removable.

No. 43 RECOVERY BED. Head and footboard panels are heavy gauge, but light weight-aluminum. Both ends removable.

● While designed primarily for the treatment of post-operative patients, Hill-Rom Recovery Beds are equally well adapted for many other uses, including eye cases, special therapy emergency cases, cardiac cases, also as labor and emergency delivery beds. For emergency delivery cases the foot end of either of the Hill-Rom Recovery Beds can be removed and standard knee crutches inserted in the foot end sockets.

Both beds are equipped with No. 25-1 Trendelenburg springs, telescoping sideguards of aluminum, two wheels with brakes, and swivelocks. Fracture equipment can be mounted on the beds, and there are six positions for the Irrigator Rod. For use in examinations, we recommend that a Hill-Rom Safety Step be attached to the spring.

For further details of these multi-purpose beds write for Procedure Manual No. 2, written by Alice Price, R.N., M.A., Nurse Consultant for Hill-Rom Co. and author of "The Art, Science and Spirit of Nursing."

HILL-ROM COMPANY, INC. · BATESVILLE, INDIANA

Safety sides do not interfere with use of the patient control panel.

HILL-ROM ANNOUNCES THE FIRST *All-Electric "Push Button"* HILOW BED

● This all-new, all-electric "push button" Hill-Rom Hilow bed sets an entirely new standard for convenience, utility and patient comfort, and is the last word in adjustable height bed design and performance. It is designed so that operation of the Hilow feature and adjustment of the backrest and kneerest may be handled by the patient. As shown above, push button controls for patient use are located on the patient's right—in the seat section of the spring. If such patient operation is undesirable, the nurse can easily make it impossible by the use of "cut-out" switches on the motor unit. All switches are mechanically interlocked—no two push buttons can be operated at the same time. Head end and foot end panels are designed by Raymond Loewy.

With the addition of this new "push-button" model Hill-Rom now offers *four* different hilow beds, including both manually and electrically operated models. Complete information on any of these hilow beds will be furnished on request.

HILL-ROM COMPANY, INC., Batesville, Ind.

The nurse also finds the push button control panel is conveniently located.

NOW READY!

PROCEDURE MANUAL No. 3

Hilow Beds is the subject of Procedure Manual No. 3, prepared by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom Co., Inc. and author of three leading textbooks on nursing—The American Nurses Dictionary, A Handbook for Student Nurses and The Art, Science and Spirit of Nursing. Copies for student nurses and graduate nurse staff will be sent on request. Address Miss Alice L. Price, Hill-Rom Co., Inc., Batesville, Ind.

An interested spectator at the American College of Hospital Administrators booth is Mrs. Inkeri Vauraste, assistant to the director of hospital activities, Hospital Board of Helsinki, Finland, and currently on leave as a hospital administration student at the University of Minnesota, Minneapolis. At right is Lynn C. Wimmer, managing editor, ACHA quarterly journal.

Comic Books 'Verboten', Inhalation Therapy Needed, Ancillary Costs Unfair, Tri-Staters Told

More than 8,400 attended the 27th annual Tri-State Hospital Assembly, held recently in Chicago. Here is TOPICS' report:

High Ancillary Charges Unfair to Patient and Full-Service Program

Relating Rates to Cost Might Aid Controversy over Specialty Services

The pernicious practice of "loading" ancillary charges far above the cost of furnishing the services penalizes the very sick patient unfairly and results in the subsidization of the not-so-sick or convalescent or convenience patient by patients who require many special services.

Furthermore, as a Blue Cross man, I deplore this practice because it puts a full-service program at a considerable disadvantage when contrasted with an average indemnity insurance program. If the hospital placed a proper value on room and board and readiness to serve, a commercial insurance program would be forced to put more of its benefit into this category and would be correspondingly less adequate in its coverage of necessary extra charges—or, on the other hand—and preferably—would be impelled to adjust both benefits upward in accord with the realities of today's hospital costs.

The same criticism applies to Blue Cross programs which provide a fixed dollar benefit for a room instead of a full-service benefit for ward or semiprivate patients. Such programs—both commercial insurance and Blue Cross—put pressure on hospitals to continue these inequitable pricing policies.

If hospitals will set their rates fairly, with charges for each service geared to bring in revenues which approximate the cost of that service, the public will benefit and hospitals' public relations will be greatly improved. Total Blue Cross payments based on cost formulas will not be affected, and insurance companies will soon adjust their benefit patterns to meet the new situation.

Possibly much of the heat might be taken out of the controversy over specialty services in hospitals if these services were priced at cost or in the same relation to cost as all other services, including room and board. It even seems possible that the total hospital bill to the public might be decreased.—**William C. McNary**, Executive Vice-President, Michigan Hospital Service, Detroit.

Better PR Would Result from Basing Ancillary Service Charges on Cost

Separate Charges Should Be Made For Nursing and Professional Care

Hospital charges should be related to the cost of producing such services in order to (1) improve public relations with the patient and third parties; (2) reduce subsidization of patient to patient and from department to department, and (3) establish a basis of true comparisons of costs and charges with other hospitals.

To what extent are ancillary services carrying the burden of unprofitable departments? In our hospital's most recent cost statement our daily service charges show a 10.4 percent loss on total income from patient room service. Losses in the operating room amounted to 65 percent of income; the delivery room, 46 percent; and the emergency suite, 55 percent of total income. The pharmacy produces 30 percent profit; x-ray, 25 percent (of total film income); and laboratories, 30 percent (of laboratory determinations).

If our hospital related its daily service charge to the cost of living service, our rates would be increased 10.4 percent. Other rates would be increased too, but ancillary charges could be decreased.

It is not recommended that income from ancillary service departments exactly equal expenses. There should be a three to five percent margin of income over expense.

We formerly had a dual rate for ancillary services, except for pharmaceuticals—one rate slightly under

(Continued on next page)

cost, for county and semi-indigent patients, and the other well over cost, for those who could pay for what the traffic would bear. We discontinued it and established a single rate, because the former system bred poor public relations, produced all sorts of clerical errors, and was a poor method of accomplishing the accounting we expected from it. Furthermore, the cost of producing an x-ray is the same for a ward patient as for a private patient.

Setting ancillary rates on the basis of the cost of rendering service should be done gradually. As overall costs climbs, rates should be sufficiently increased in all "deficit units" to match increased costs. For several years we have been increasing daily service and operating room charges, while holding back on any increase in profit-making units.

Cost of nursing and professional services should be separated from the "floor" cost and charges instituted for "general nursing and professional care," including floor-stocked drugs. The room rate would then include only regular "hotel" expenses, together with meals. This rate becomes a package that the public understands and can compare with hotel rates. Nursing service is properly put into the category of a revenue-producing unit.

Physicians, patients, and third-party agencies would have to be educated. The plan would have perhaps its biggest problem with outside specialists currently charging approximately the same rates as hospitals. If hospital rates were dropped appreciably, these specialists would be forced to drop their prices or face an inquiring public.—**E. C. Laetz,** Business Manager, University Hospital, Ann Arbor, Mich.

Quality of Medical Care Threatened By Trend in Malpractice Judgments

Suggests Safeguards to Protect Staff Members from Suits

If the trend toward exorbitant judgments in malpractice cases continues, the eventual result may be a decrease in the quality and an increase in the cost of medical care.

It is alarming to find the doctrine of "*res i*
loquitur" (the thing speaks for itself) being
plied more and more to professional liability ca
Historically it was applied in cases of falling obj
explosions, and railroad derailments, for instan
cases in which the object was in the exclusive co
of the defendant and the accident was one which w
not ordinarily occur in the absence of someone's
ligence.

Increasing application of this theory against ph
cians could result ultimately in making the physi
a guarantor of his results. This is practically an
possibility.

Federal hospital administrators have a greater
cupational hazard in the way of professional liab
claims because in federal cases the administrato
commonly included in a suit, as it is assumed that
he hires the personnel concerned, he would have
rigid supervisory control and more authority.

Suggested safeguards recommended for medical
members to protect them against suits include: g
medical records; tact; use of only sound, accepted
fessional practices; exhaustive efforts at diagnosis
fore treatment; careful supervision of assistants;
free advice; no telephone prescriptions; no diagn
by telephone except in emergency; no controver
procedures (such as sterilization operations) for ot
than strictly medical reasons; no over-optimistic pr
noses; no unethical professional criticism; written
witnessed authority for autopsy examinations; no ne
less talk, and written notice to patients of any unus
risk or danger.

The term "malpractice" should be dropped in fa
of "professional liability."—**Rear Adm. Frank P. G
more, MC, USN,** Assistant Deputy Chief, Bureau
Medicine and Surgery for Planning and Logistics, Wa
ington, D.C.

Gehrke Heads New National Purchasing Agents' Group

Edward W. Gehrke, director of procurement and supp
Baylor University Hospital, Dallas, Tex., is preside
of the newly organized National Association of H
pital Purchasing Agents.

**Enjoying a chat before the Federal Hospitals banquet are (l. to r., first row): Lt. R. E. Hunter, MSC, USN, admitting officer, Hospital Corps School, Great Lakes, Ill.; Lt. Joseph C. Boudreaux, chief pharmacist, and Robert G. DeVine, Lt. j.g., security officer, U. S. Naval Hospital, Great Lakes. Second row: Cdr. J. N. Collins, executive officer, Hospital Corps School, Great La
Lt. Cdr. F. L. Mayberry, MSC, USN, admitting officer, and Alli
N. Kendrick, Lt. j.g., MSC, USN, assistant chief, personnel
ords, U. S. Naval Hospital, and Ensign Billy D. Roberts, M
USN, administrative assistant, dependents' hospital, Great La**

Admiring citation presented to Laura Jackson at the Tri-State luncheon for her services to state association hospital personnel is Dyke Brown, vice-president, Ford Foundation, New York City, who accepted a citation for the foundation. State awards of merit were presented to Guy W. Spring, executive director, Blue Cross Hospital Service, Indianapolis, Ind.; Edmund B. Fitzgerald, president, Northwestern Mutual Life Insurance Co., Milwaukee, Wis.; Roger W. DeBusk, M.D., director, Grace Hospital, Detroit, Mich., and the Rev. Joseph A. George, administrator, Evangelical Deaconess Hospital, Chicago.

Formation of the group was announced at the Tri-State Hospital Assembly. Mr. Gehrke is also president, Hospital Purchasing Agents Association of Texas.

Other officers are Harold Springer, purchasing director, Presbyterian-St. Luke's Hospital, Chicago, vice-president, and Mrs. Orpha Daly Mohr, purchasing agent, Chicago Wesley Memorial Hospital, secretary-treasurer.

Purchasing Agent, Not Pharmacist, Should Purchase Drugs

Buying Directly from Manufacturer
Good Business Practice

The purchasing agent should purchase drugs, if possible. The pharmacist has enough to do without becoming involved with the intricacies of purchasing.

All hospitals should make every effort to buy drugs directly from the manufacturer. Generally the hospital has to be no larger that 10 beds to qualify for direct purchases. This usually represents savings of from 10 to 50 percent.

In buying directly, it is good practice to use the inquiry system, listing all items you may need from one manufacturer during a 30-day period, or shorter length of time.

The letter should be sent directly to the company concerned, with a copy to the local representative. Often the salesman is authorized to quote lower prices; usually the company will quote the lower prices. Local drug wholesale houses sometimes can quote lower prices than the direct source. The practice of looking for lower prices in the drug field leads to sound business policy, better relations between purchaser and vendor, and often savings to patients.

The inquiry system also aids emergency purchasing, as the buyer will be familiar with the best sources.

We use two types of orders—the blanket order and spot-buy order. The blanket order is issued to various drug houses. It runs for a three-month period and contains all items we may release during that period. All releasing against this type of order is done by the pharmacy stock man, thus relieving the purchasing agent. It saves a great deal of time, money and effort.

The spot-buy order concerns only those items requested probably once or twice every 30 to 60 days. This type of order is handled from start to finish by the purchasing agent. Any item that can possibly be put on a blanket order should be done so at once to save time. — **Kenneth L. Acker**, Purchasing Agent, Henry Ford Hospital, Detroit.

Purchasing Agents' Group Corrects Trade Abuses, Advances Profession

Promotes Sounder Purchasing Methods,
Better Salesman-Buyer Understanding

The Hospital Purchasing Agents Association of Texas was organized April 3, 1956. We had 28 members at first, and now have 41.

The association, as a group, can promote sounder purchasing methods in hospitals by collecting and exchanging useful information on various sources of supply and distribution, and various kinds of products and their uses. This information is printed in readable and understandable form and distributed to all hospitals for their use, or presented at purchasing forums or other meetings.

We are better able to correct many existing trade abuses, and advance the hospital purchasing profession, and can help all hospitals in certain fundamentals of purchasing, such as buying the best materials in the best quantities at the right time and right price.

Economy-wise we can be of assistance regarding quantity buying. We can also promote better understanding between salesman and buyer.

We can be of assistance through our experiences in setting up standard procedures in purchasing and storeroom control, and standards in equipment and supplies. —**E. W. Gehrke**, Director of Procurement and Supply, Baylor University Hospital, Dallas, and President, Hospital Purchasing Agents Association of Texas.

Good Food Service Possible Without Outside Help

Try to Analyze Department
To Find Where Trouble Is

Operating your own dietary department offers better management because the closer management is to the people that are doing the work, the better the operation of the department. The profit that would normally go to a catering service could be applied to improving the dietary department. Group purchasing can be done by the hospital. Many cities have hospital councils which do group purchasing.

The administrator, using good cost-control practices and working with the food service manager and business manager, can arrive at excellent cost controls. Decisions should be made at the location. Any decision affecting the dietary department can't be made from an office 150 miles away.

If you are having trouble in your dietary department, here are basic steps to follow before you take any action. Examine your dietary department—for all the good things you have, the things which are right and

(Continued on next page)

basic for the efficient operation of the department. Check the amount of space allocated, the work flow, the equipment, and the number and quality of personnel. Examine the department for all the things which don't come up to the standards. Check your food service manager and see if good management is being employed. Examine the cafeteria foods, patient diets, and the therapeutic diets.

After you have checked the problems, try to find a common denominator. Is the problem basically one of poor organization, management, or design, for instance?

List your remedies. Then correct the problems which you believe to be the basis for the other problems. Follow up and keep an eye on the department.—**David D. Kramer,** Assistant Administrator, Elkhart (Ind.) General Hospital.

Food Service Management Used To Overhaul Existing Service

Dietitian Has More Time
To Spend with Patients

Food service management was called into the hospital to provide a hard-headed business background to overhaul the existing food service facilities.

Selective menus were introduced as a step toward improving the food service.

The dietitian, relieved of the responsibility of food preparation, had time to spend with the patients to help them understand their problems.

Improvement in quality has been brought about by the control of raw foodstuffs, workers, equipment, and conditions under which the food is produced.

The total food cost is higher under the new management than previously. However, the service was tailored to upgrade the quality of food and service, not to reduce expense. Improvement is well worth the few additional cents per meal.

Two dietitians have been supplied. A chef-manager and assistant complete the management team.

The dietary department functions as an integral pa of the hospital operating to the specifications of the in stitution.—**Bertha R. Judson,** Administrator, Woodlaw Hospital, Chicago.

Library Should Stimulate Better Patient Care

Books Should Be Placed
On Open Shelves

The ultimate goal of a hospital library is to provi sources which may stimulate better care of the patien

A good library should have its holdings accessibl on open shelves, never behind locked glass doo Classifications and cataloguing should be used co sistently. Library regulations should be available and understood by the users.

Acceptable withdrawals and loan systems shou be established. A reserve book section should b maintained. Provisions should be made for inte library loans with other agencies. Users should b kept informed of new acquisitions through notice posters and displays.

Library hours should be conducive to effective us Proper orientation should be provided to the variou groups using the facilities. Library committee mi utes should be kept to provide a running account o activities and growth.—**Hazel A. Goff, R.N.,** Director of Nursing, Madison (Wis.) General Hospital.

Inhalation Therapy Department Called Essential to Hospital

Patients and Staff Like It;
Services' Income Almost Tripled

An inhalation therapy department is essential in a modern hospital. Our department is now a year old. We find three principal advantages:

(1) Added service to the patient. We had previously had many requests for various specialized phases of inhalation therapy which we often could not fulfill because of lack of trained personnel. Today five inhalation therapists are busy at all times, staff doctors have utilized our service to the fullest extent, and patients

Participating in a panel discussion on "The Necessity of Establishing Inhalation Therapy Departments in Hospitals" were (l. to r.): Lawrence Fruik, supervisor, inhalation therapy department, and Frank W. Brown, administrator, Edgewater Hospital; Edwin R. Levine, M.D., medical director, Titus Werner Clinic, and assistant professor of clinical medicine, Chicago Medical School, and Donald Gilbert, supervisor, inhalation therapy department, University Hospitals, Ann Arbor, Mich., and chairman, board of directors, AAIT.

are more adequately served and their recovery is more rapid.

(2) Relief of overburdened nurses of this highly specialized service.

(3) More equitable charges to patients, fewer complaints from them over that phase of the bill, and more sound public relations. Previously, when nurses, engineers, and handymen placed inhalation therapy in patients' rooms, the patient sometimes was overcharged after treatment was discontinued. Conversely, many patients who received inhalation therapy had no charge rendered at all.

The income from this department has been almost tripled in the last 12 months. Ours is a 300-bed hospital with 12,000 admissions a year. But even smaller hospitals of 50, 75, or 100 beds could well have a full-time inhalation therapist. Jobs might be combined. An inhalation therapist might be used as a male orderly if he is not needed full-time.—**Frank W. Brown**, Administrator, Edgewater Hospital, Chicago.

Tells Administrative Problems Arising in Medicare Program

Only Semiprivate Rate or Equivalent Is Payable by Government

Administrative problems which have arisen so far in the Medicare program include the following:

(1) Some medical institutions have been unable to receive payment from the government because they do not meet the definition of a hospital established in the joint directive promulgated by the Secretary of Defense. An institution must be operated in accordance with the laws of its jurisdiction pertaining to hospitals; must be primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnoses and for treatment and care of injured and sick persons; must have two or more staff physicians or surgeons, and must provide 24-hour continuous nursing service by registered graduate nurses.

(2) Some institutions have only ward accommodations or private rooms — no semiprivate accommodations. These hospitals may participate in the program, provided that the hospital bills the government for the lower cost of ward accommodations or an amount appropriate as a semiprivate room charge when only private rooms are available. When a hospital has only private rooms and will not accept as payment in full the semiprivate rate payable by the government, the difference in cost becomes the liability of the patient.

(3) Some hospitals have submitted bills for cases when the patient was hospitalized solely for dental treatment. Such bills are not payable. If hospitalization for dental care is to be included, the patient must be hospitalized primarily for a medical or surgical condition, and the attending physician and a dentist must agree that dental care is necessary as an adjunct to that condition.

(4) Some hospitals have submitted bills for hospitalization of dependents with nervous and mental disorders when such hospitalization was not for an acute emergency. Payment for such disorders is included only in cases of acute emergency, and in such cases the government's liability terminates after 21 days, unless a specific authorization for a longer period is granted.

(5) Some hospitals have submitted bills for mothers and other dependents who are not authorized for care in civilian sources. Great care should be taken to establish the eligibility of a dependent, in order to assure prompt and appropriate payment.

Approximately 40 percent of 5,000 physician claims analyzed were for obstetrical and maternity care, and 18 percent were for tonsillectomies. An analysis of 500 physicians' bills indicated that approximately 25.4 percent of the dependents who have received care under the program were residing apart from their sponsor, because of exigencies of the service.—**Lt. Col. Ralph J. Richards, Jr., MSC**, Director for Operations and Management, Office for Dependents' Medical Care, Department of the Army, Office of the Surgeon General, Washington, D. C.

No Excuse for Stocking Comic Books, Librarians Told

Speaker Suggests Picture Books, Humor, Adventure Instead

In selecting paper-backed books for hospital libraries, the librarian should use the same good standards as for books with more permanent covers.

A principal advantage of paper-backed books is ease in handling. Disadvantages are: they tear, and they become dirty and unsightly. The librarian should not buy them unless she is willing to throw them out when they look unsightly. Records should therefore be simple.

There is no real excuse for an ordinary library to have comic books, because librarians can recognize that there are good comics and bad comics—but children can't. It is preferable to buy books that have a similar appeal—picture books and books of humor and adventure. Adults will read these too.

If a librarian is purchasing comic books, she can obtain a list of criteria for judging them from the Committee on Evaluation of Comic Books, P. O. Box 1486, Cincinnati.—**Sarah I. Fenwick**, Faculty, Graduate Library School, University of Chicago.

Hospital Reports Success With Food Service Supervisor

Doctors, Patients Compliment Results; Food Costs Decrease

There is a real need for the trained food service supervisor in the dietary department. She must be trained. Our supervisor had worked for us for seven years but would not have been able to perform her present duties without training.

Since she took charge, we have had compliments on food service from patients, and a decrease in food costs. We are not able to achieve quite the flexibility of diet that we might with a dietitian. However, the medical staff has gone out of its way to compliment the kitchen staff on its diet and special diets.

We made arrangements for a local retired dietitian to act as consultant on difficult problems, but as yet we have not had to call her.

Procedure books are important when there is no professional dietitian in charge.

We still want a dietitian, and I believe we will have

(Continued on next page)

an attractive set-up to appeal to a dietitian. From our experience, however, we wonder whether a hospital is justified in employing a professional dietitian to do things we have found our trained food service supervisor can do effectively.—**Jane S. Davis**, Administrator, Pawating Hospital, Niles, Mich.

Rehabilitation Nursing Stressed At Physical Medicine Institute

Aim is to Prevent Patient from Becoming Debilitated

The Institute of Physical Medicine and Rehabilitation has two divisions—the Forest Home division of St. Francis Hospital, and the Methodist Hospital division.

During the past six years the institute has developed for both hospitals (total, 1,000 beds) a complete physical medicine rehabilitation diagnostic and treatment service.

The institute occupies the entire floor in both hospitals. It is administered by a nonsectarian, nonpolitical board which is responsible for operating policies, community relationships and budgets for operation and expansion of the program. The medical advisory committee, composed of medical staff representatives from both hospitals, advises the board in establishing and maintaining policies regarding medical practices.

A selected 16-bed area was put into operation as a pilot study at St. Francis Hospital. Staff nursing personnel were trained. A student nurse program was set up, first on an elective basis and later by routine rotation of senior students.

Rehabilitation nursing is good modern nursing care for the chronically ill and disabled. It can be incorporated into any school of nursing curriculum without adding to the total clock hours. At present the student nurse receives 16 hours of lectures and two months of clinical training on the rehabilitation service.

The aim of rehabilitation nursing is to prevent the patient from becoming debilitated during his illness, and to encourage him to think about getting up, doing things for himself, and getting discharged as soon as possible.

The nurse is brought back to the bedside in rehabilitation nursing. Her skills are concentrated on fewer patients. The care rendered is highly individualized.—**Margaret Ryan, M.D.**, Chief, Medical Social Service Section, and **H. Worley Kendall, M.D.**, Medical Director, Institute of Physical Medicine and Rehabilitation, Peoria, Ill.

18 Scholarship Loans Available In Community for Nursing Students

Students Repay Half of Loan; Offer Services to Hospital

Eighteen scholarship loans of $450 are available in our community to aid girls in financing nurses' training.

One of the conditions of the loan is that the student, upon graduation, shall *offer* her services to our hospital for 18 months, at the prevailing rate of remuneration for such services.

A loan can be granted only to a girl who has been previously accepted by a nursing school. The money is advanced over a three-year period and is generally proportioned to tuition and school needs. The student is obligated to pay back at least one-half the amount advanced within two years after graduation, interest-free.

The contract further provides that if the student does not fulfill these provisions, the full amount of all advances shall be due and payable with interest at six percent per year within three years from the date of completion of training, or one year from the date of cessation, if she does not complete training.

If there were no requirement for at least partial return of the loan, it wouldn't be long before there would be no more scholarships. Each recipient returning money knows that she is helping to make it possible for another girl to have the benefit of a scholarship loan.

Moreover, most of the scholarships were provided by local service organizations from their educational funds. Many of these organizations have rules governing use of these funds, which provide for some refunding.

Of the 23 girls who have received loans, 10 have not completed the course, seven have finished training, and six are in training at this time. Five of the seven graduates have returned to work at the hospital. Four are still on the staff; the fifth is married and has a family.

A committee appointed by the hospital board is solely responsible for selecting candidates. It includes five women—two school teachers (one is also a doctor's wife), one hospital board member, and two interested women who are active in the community.

We also have a program under which high school students are selected for training similar to nurses' aide training, except that some duties aides are permitted to do are not included. To be eligible for participation in this program, girls must be interested in entering the nursing profession. They are given two weeks' training. As soon as they are started on the nursing unit, they go on the payroll at $60 a month, and are given an on-duty meal and laundry of their pinafores.

We are now trying to evaluate this program (now two years old) to see whether we can require participation in it before a girl could be considered eligible for a scholarship. All these students who have later entered nurses' training are still in training, whether they went on scholarships or not. They knew what they were going to encounter.—**Shirley M. Lindberg, R.N.**, Administrator, Marion (Ill.) Memorial Hospital.

Outlines Duties of Medical Staff to Hospital, Patients

Physician Should Ascertain Whether Special Equipment Needed Is Available

Medical staff members have two types of responsibilities: to the hospital and to the patients. Their duties to the hospital include advising governing authorities regarding clinical and scientific work and participating in staff activities, such as determining fitness of physicians for practice in the hospital, fixing a standard for applicants, and serving on the tissue committee.

As a practical matter, these responsibilities can be enforced only through disciplines which the hospital itself may adopt.

Responsibilities to patients could be classified into two varieties: those to the hospital or governing authority (concerning care of patients) and those to the

Above: Getting together after the ACHA luncheon are (l. to r.): William L. Thompson, administrator, Peoples Hospital, St. Louis, Mo.; Clyde L. Reynolds, administrator, John P. Douglass, controller, and George C. Allen, administrative assistant, Provident Hospital, Chicago.

At right: Discussing a session they have attended are Sister Rosalie (l.), nursery supervisor, and Sister Mary Thecla, supervisor of delivery room, both from Resurrection Hospital, Chicago.

patient in the hospital. It is the duty of the physician to ascertain whether the hospital is equipped to carry out the procedures necessary for the treatment for which he hospitalized the patient. If he needs the services of highly specialized technicians, or medicines not usually found in the hospital's supply, he should see that they are available.

The general principle of the law is that to be free from negligence, the physician must do the thing that the ordinarily cautious and skillful physician would do today under the same or like circumstances. The principle has not changed.

The physician is responsible for making his orders and directions clear. While he should conform to the rules of the hospital, ordinarily breach of them subjects him only to the disciplinary measures of the hospital, unless the patient is injured thereby.—**Albert Stump, LL.D.**, Indianapolis, Ind.

Centralized Personnel Function Necessary in All Hospitals

Reduces Turnover, Saves Time, Carries Out Policies Uniformly

If a hospital has 100 beds, it cannot afford not to have a full-time personnel department. In a small hospital, someone with training and interest in personnel can combine the personnel function with another job, but it should be centralized. Two persons are needed in a 150-bed hospital.

Advantages of a central personnel department are: general administrative policies of personnel are placed in writing, and there is assurance that such policies are being carried out in a uniform manner. Employees have access to a third party to whom they can take problems. If you have a personnel department, you can be more effective in reducing turnover.

Indirect advantages include elimination of the waste of time when a department head has to interview dozens of applicants or when two departments advertise and spend time interviewing applicants for almost similar jobs. Sometimes one department will advertise and obtain applicants, not realizing another department has similar needs.—**Mortimer W. Zimmerman, M.B.A.**, Executive Director, Weiss Memorial Hospital, Chicago.

Says TB Still Heads List of Infectious-Contagious Diseases

Chronic Alcoholic with TB Becoming More of a Problem

Tuberculosis is still the number 1 infectious-contagious disease. The aging population needs good rehabilitation. Long-term follow-up and close cooperation with health agencies is necessary.

The chief treatment problem is recalcitrance and the patient who leaves against medical advice. Active carriers avoid caseworkers or visiting nurses.

Forty-five percent of active TB cases are under home treatment. Not all are getting proper drugs and rest.

The chronic alcoholic with TB in large metropolitan areas is more and more of a problem. Some means of forcible isolation is called for. If patients remain hospitalized long enough to become negative and can be persuaded to accept chemotherapy, this would help. They must get streptomycin shots twice a week, and must be prevented from becoming a public health hazard.—**Karl H. Pfuetze, M.D.**, Medical Director and Superintendent, Chicago State Tuberculosis Sanitarium.

No Long-Continued Observation In Mass X-Ray Programs

Need to Concentrate Surveys in Groups with High Incidence

Many persons x-rayed in mass programs are groups easy to reach, such as employees of large industries, and high school or college students. There is a tendency to repeat tests in the same location and get about the same results. There is a failure to obtain long-continued observation.

Surveys should be concentrated in groups where evidence is high, such as mental hospital patients and relief recipients. X-rays should be required for relief recipients. Vagrants and alcoholics are also susceptible groups. Many are lost to examiners in follow-up. Those to be watched are persons in selective industries which employ unskilled labor (such as restaurants), persons in older age brackets, racial groups, and physicians and nurses.—**E. R. Krumbiegel, M.D.**, Commissioner of Health, Milwaukee, Wis.

Westerners Discuss Nursing Supervision, Communication, Unit Design

● Approximately 3,500 attended the 27th annual convention of the Association of Western Hospitals May 6-9 in Los Angeles. Ralph Hromadka (r.), superintendent, Santa Monica (Calif.) Hospital, was named president-elect. Guy M. Hanner, administrator, Good Samaritan Hospital, Phoenix, Ariz., became president. Other officers are Wesley G. Lamer, administrator, Physicians and Surgeons Hospital, Portland, Ore., first vice-president; Paul R. Hoff, administrator, Bannock Memorial Hospital, Pocatello, Ida., second vice-president; and Sister Mary Bede, administrator, Sacred Heart Hospital, Spokane, Wash., third vice-president.

There was much talk of a Western revolt against the AHA proposal for a 50 percent temporary dues increase, but only a few Westerners voted against the increase at the AHA House of Delegates' meeting May 18 (see page 9).

TOPICS' report follows.

Tensions in Hospital Organization May Have Effect on Patient

Employee May Distort Administrator Unless Good Communications Exist

We need a new science of administrative therapy—recognizing that anything that happens anywhere in the hospital may affect the patient. Since the patient's body is in open communication not only with the natural world around him but with the personal and social world, tension and uneasiness in the hospital organization can get into the patient's body illness.

One of the outmoded concepts which we still hold is that the patient has a passive role—he is someone to whom the hospital does something. We tend to think that the patient is a thing. The patient expects certain things from the hospital, and the hospital has its set of expectancies—how it wants the patient to be sick. Sickness used to be something which was played out in the family; now the sick role is played out in the hospital.

One-third of all hospital beds are occupied by patients who are using the sick role for a different experience than being sick—for diagnosis, for example. The answer is not necessarily to build more hospitals, but to use the ones we have more intelligently.

An administrative chart (of hospital organization) is important because it is a model of the hospital. It

Past presidents and other officers are (l. to r., front row): Guy M. Hanner, administrator, Good Samaritan Hospital, Phoenix, Ariz., president; Wallace F. Vail, Los Angeles, first president, from January, 1927, to May, 1928; Alfred E. Maffly, administrator, Herrick Memorial Hospital, Berkeley, Calif., outgoing president, and Mrs. Cecile Tracy Spry, superintendent, General Hospital, Everett, Wash. Back row (l. to r.): Horace Turner, superintendent, Kadlec Methodist Hospital, Richland, Wash.; Wesely G. Lamer, administrator, Physicians and Surgeons Hospital, Portland, Ore., first vice-president; F. O. McVey, second vice-president, and hospital consultant, New Mexico; Frank C. Gabriel, Eastern New Mexico Medical Center, Roswell; Orville N. Booth, administrator, St. Francis Memorial Hospital, San Francisco; John A. Dare, administrator, Virginia Mason Hospital, Seattle; Donald S. Showman, administrator, Kennedy Deaconess Hospital, Havre, Mont.; Ritz E. Heerman, general manager, Lutheran Hospital Society of Southern California, Los Angeles, and A. A. Aita, supt., San Antonio Community Hospital, Upland, Cal.

is at the same time a communications network. Emotions can get communicated along this network.

If an administrator does not have good communications with his employees, the employees tend to exaggerate and distort the administrator. It doesn't do to have an "open door" if nobody comes to the door. The administrator for whom employees work is not the real administrator. They have a mental image of him. It doesn't matter how benign he is—if their mental image is of something different, the image is the one they work for.

It is surprising how many hospitals are run on the "conspiratorial system." The administrator is the supposed conspirator—the "they" whom employees mention. Hospital employees take the role of counter-conspirators.

If we do not give psychological satisfactions to our employees, we are going to have to give higher wages and more material benefits.—**Edward Stainbrook, Ph.D., M.D.**, Chief, Department of Psychiatry, University of Southern California School of Medicine, Los Angeles.

Six Communication Methods Upward Available to Hospital Employees

Suggestion System Could Be Improved If Administrator Listed Problems

Six specific methods of communication upward which are available to employees include three oral and three written. The written methods are individual reports, statistical or analytical summary reports, and suggestion systems.

When a report is placed in your hands, do you (the administrator) always follow through? Do you read it, comment on it, and tell what is going to happen? If a carefully written report is put in a folder and forgotten, we employees wonder whether our efforts were worthwhile.

An analytical summary of reports—such as an employee's sick-leave record, for instance—may give insight into employee's problems.

We employees like suggestion-box systems, but realize that improvements are needed. Why couldn't the administrator, through the bulletin board or the hospital paper, give us a list of problems to work on? One way of securing a list of problems is to ask department heads, for instance, to write down troublesome areas in procedures or work methods, preceding every statement with "how to."

Administrators express regret about the number of complaints received in the suggestion box. But isn't it better to receive both suggestions and complaints than to get neither?

Suggestions should be acknowledged and evaluated within two or three weeks. Following this rule will contribute greatly to the success of a suggestion-box system.

Three types of oral communication are the grapevine, the interview, and group meetings. Whether or not you like it, the grapevine can be depended upon to work speedily and without any regard to truth or consequences.

The personal interview can be an effective means of communication, but offers several problems. There is a popular fallacy that if you permit an employee to come to you and blow off steam, his complaint will be dissipated. If the problem is outside himself, the employee wants and needs a solution.

Employees like group meetings at which they have an opportunity to talk things over and ask questions. They welcome a chance to express themselves, but do not want to usurp the administrator's or department head's authority to make the final decision. — **Mrs. Verna Dull**, Public Relations Assistant, Pomona Valley Community Hospital, Pomona, Calif.

Does Nurse Fear Supervision? Administrator — Yes; Nurse — No

Nurse Trained for Personal Service; Hard to Change Attitudes

We have changed our concepts of nursing service—but has the general-duty nurse changed her concepts? There is still a strong resistance by nursing personnel to the taking over of duties by auxiliary personnel. Furthermore, there is little knowledge of supervisory technics, and there is resistance to taking over supervisory duties. The nurse does not fear the auxiliary worker as a threat to her job, but fears her because her presence may mean that the nurse will have to take on supervisory duties.

This very devotion to the personal-service concept poses a problem. Such attitudes are instilled in training. Can something be done during training to make the student realize that she will be called upon to supervise? Would it be too radical to propose that the student be exposed to a short course in hospital economics?

We should design nursing units for maximum efficiency. Our most modern hospitals have not been able to make any appreciable reduction in the number of nursing hours required per patient.—**James E. Smits**, Administrator, Children's Hospital, Los Angeles.

More Training Needed for Supervision; Also Education on Nurse's Role

I question the statement that nurses do not want to do supervision. I believe basically that no one wants to do what he does not understand. Much must be done to change the attitudes of administrators—and also attitudes of doctors as to what is the role of the nurse.

Nurses formerly were taught to be "trained hands." They were not taught to understand people—to work with people and organize them. They need training to take on supervisory duties.

The most expensive thing in the hospital is the salaries of your nursing personnel. If you can save those, you may be able to save money for the hospital, and perhaps for the patients. An intensive therapy unit, with everything needed close by, can give patients excellent nursing care and save nurses' steps by putting in one area all patients who require a great deal of attention.—**Nina Bethea Craft, R.N.**, Former Director, Nursing Services and Education, Los Angeles County General Hospital, Los Angeles.

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"Why not establish an evening school of nursing?" one administrator in the audience at the nursing discussion wanted to know. He suggested that older women—many of whom are now entering practical nursing—might be recruited for the nursing profession.

(Continued on next page)

Speaker and honored guests at the general session on "Current Practices of Financing Hospital Care" were (back row, l. to r.): Edward C. Rosenow, Jr., M.D., immediate past president, Los Angeles County Medical Society; Kenneth E. Knapp, Ogden, Utah, president, Utah Hospital Association; W. A. Day, Elko, Nev., president, Hospital Administrative Council of Nevada; W. W. Stadel, M.D., San Diego, president, California Hospital Association; and Robert J. Thomas, director, Los Angeles County General Hospital.

Front row (l. to r.): Guy M. Hanner, incoming president of Western; Everett W. Jones, hospital consultant, Fort Myers Beach, Fla.; A. J. Swanson, Toronto, Ont., president, American College of Hospital Administrators; and Joseph E. Zem, director, St. Luke's Hospital, San Francisco.

MRL Can Prepare from Records Report Revealing Quality of Care

Desire for Credit Can Stimulate Physicians to Complete Records

Would not a positive approach be more effective than a negative one in solving the problem of medical record completion? Why could not the medical record librarian prepare monthly reports of what has been done, based on the doctor's own account of his work as he has recorded it in the clinical records?

To be effective, both social and medical data should be included in sufficient detail to reflect not only what has been recorded, but also what has been omitted.

In relatively few hospitals have medical librarians expanded the scope of their duties to include utilization of the record to prepare reports which will clearly portray the characteristics of their specific hospital. It is not enough to know how many admissions, births, discharges, and deaths occur annually. We might begin with tabulating age groups, sex, and frequency of admission of each person discharged during an annual period, for use in determining the true hospital fatality rate and the extent to which hospital facilities are being used by initially admitted and re-admitted patients.

Needless to say, such information cannot be tabulated from incomplete records. A reasonable length of time should be given the staff to enable them to complete the records of their patients. A delay of three months is not excessive if the objective is to prepare a report from the completed records.

In all areas of tabulation, a category entitled "Unknown or Not Recorded" should be included. The extent to which it is necessary to tabulate to this category provides the administrator with a valuable measure of the quality of the records and the diligence of the staff in completing them. Thus a positive approach is made toward creating a desire among the staff to keep their records current.

Such a monthly report can become the conscience of the hospital. Every doctor will want to receive credit for work he has done, and will not want to be found lacking when his work is compared with that of other doctors bringing patients into the hospital. This report can also become an administrative tool to help make determinations in staffing the hospital, based on the services the physicians give the hospital in return for the privilege of using the hospital facilities for the care of their patients.—**Mrs. Cleo B. Nelson, C.R.L.,** Veterans Administration Center, Los Angeles.

Savings Best Achieved By Standardization Program

Management Backing, Departmental Cooperation Are Important

Good hospital standardization programs provide cost savings and at the same time protect the quality of the items you buy. Benefits include: fewer inventory problems, because the number of items on hand is reduced; lower inventory investment, because reducing the number of items carried automatically lowers the cost; fewer physical handling problems; quicker availability of equipment and parts; lower costs; less paper work, and time to do a more professional job of purchasing.

How do you develop a standardization program? First you must reduce the variety and types of equipment used. Look over supplies charged to certain departments—ask why they are stocked. Review all duplicate items, and then take up with management and departments the possibility of cutting them down to one item. It is very important to get the backing of management and the cooperation of all the departments. Great tact is needed to handle this successfully, but it can be done.—**Harlan Eastman,** Director of Purchases, Clary Corp., San Gabriel, Calif.

Back Orders Inevitable, But Can Be Reduced to Minimum

Correct Requisitions, Close Check On Suppliers, Among Remedies

Back orders happen to everyone, but they can be kept to a minimum by careful purchasing. Some of the reasons for them are:

- Incorrect or insufficient information on requisitions, which leads to stocking an unwanted item and possible back-ordering of the correct one. Wrong or illegible requisitions should always be returned, never sent out.

• Failure to order in time. Never wait until a deadline is near before ordering.

• Failure to check with vendors before sending out an order. A phone call first is never as expensive as an emergency back order. Follow-up is necessary when the order reaches the vendor, too, to make sure the item is still available.

• Placing orders for partial shipment. Hoping the balance will arrive in time is wrong; it usually doesn't. Buying from several vendors is better, even if it costs more.

• Reluctance to cancel an order from a regular supplier. Canceled orders, however, are a great help in getting better service in the future.

• Incorrect information from the vendor. Always know your supplier, so that you can be sure he will never say he has an item if he hasn't. Find out if he has adequate stocks and a good accounting system.

• Receiving systems. Sometimes purchasing departments discover that a back order has been received without the department's knowledge. A central receiving system is the only solution to this problem.—**Phillip G. Duffy**, Purchasing Agent, Stanford Universisty, Palo Alto, Calif.

Social Service Statistics Must Include Clinical Data, Record of Work Done

Results Help Social Worker As Well as Administrator

Social service statistics must make clinical data available and should provide a meaningful summary of the work being done. In setting up statistical data, help should be solicited from the medical record librarian or other qualified personnel trained in statistics.

One method of gathering statistics includes a monthly breakdown of the hospital by wards, the number of patients treated in each ward, and the number from each referred to social service. Statistics could also be gathered on age groups, diagnostic categories, and number of days of hospital care.

Such statistics, kept over a series of months, show the hospital administrator and the social service department exactly what percentage of the total patients are cared for by social service. They show which wards have the fewest or no referrals, can tell which age groups require the most attention, and help greatly in evaluating many phases of the department's work.

Also useful are yearly summaries and social service reports on the number of cases opened and closed each month, those carried forward, those referred but not opened, and time expended on each case.

Work-load standards for the case worker are extremely important. One hospital took a small sampling of cases and had each social worker fill out a form setting down the time expended on each case. Results were used to determine the average time expended and such things as bad planning on the part of the case worker, and too long or too short interviews.—**Mrs. Mary Novick**, Visiting Associate Professor of Social Welfare, School of Social Welfare, University of California at Los Angeles.

Preserving Patient-Nurse Contact Vital in Nursing Unit Design

Room to Work, Comfort, Cheerfulness, Accessibility, Termed Most Important

Erasing the institutional look is most important in designing a nursing unit. Function and human psychology should be considered as important as streamlining and efficiency.

Among important things architects can do to make nursing units more attractive are: concentrate on ceiling design, since a patient's view is horizontal as well as vertical; consider how to effectively hide all the electrical outlets which make a room look industrial (putting them in the top of a built-in bedstand might be helpful); and make electrical light fixtures, particularly in corridors, more attractive, so that they will shed a more cheerful light.—**Charles H. Coogan**, Architectural Consultant, Department of Public Health, Bureau of Hospitals, State of California, Berkeley.

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A nursing station should be as functional as possible and should provide adequate working space for the nurse, doctors who want to do charting, and other staff personnel passing in and out of the station.

We redesigned the unit in our hospital so that there is plenty of room for everyone. At one side of the station there is space for two persons to work; one sits at a low desk, the other up higher at another desk built above the lower one. For charting, we have a drum-type chart unit with room for two people on each side of it. Doctors can sit on one side to do charting, and nurses can use the other without disturbing them. There is also space in the station for the dietitian to work.

The nursing station is easily accessible to the pneumatic tube system, and a hall leads directly to the utility and "med prep" rooms. Another improvement is a lowered acoustical ceiling with strategically placed fluorescent lights.—**Clarence E. Wonnacott**, Adminis-

(Continued on next page)

Below, left: L. S. Rambeck, administrator, and Philip J. Gillette, assistant administrator, both of University Hospital, Seattle, Wash., compare notes between sessions. At right: Breakfasting in the coffee lounge on the terrace were (l. to r.): Althea M. Knerl, R.N., nurse anesthetist, Holy Cross Hospital, Salt Lake City, Utah; Juanita Jenkins, physical therapist, Oakland (Calif.) VA Hospital, and John Vandersteen, R.N., anesthetist, Cooley Memorial Hospital, Brigham, Utah.

Above: Joseph E. Zem (behind table) answers questions of Julie Kenney (second from l.), record librarian, O'Connor Hospital, San Jose, Calif., and Dora Lord, administrative assistant, Southern Nevada Memorial Hospital, Las Vegas, after his talk on third-party billing. At left is Albert Whitehall, associate director, Life Insurance Association of America, New York City.

trator, Latter-day Saints Hospital, Salt Lake City, Utah.

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Moderation is important in installing labor-saving devices. We must realize that push buttons cannot take the place of service or human contact, which is what most sick persons require. Frequently, a ring for a glass of water means simply that the patient wants to have some personal contact rather than a drink of water. Installing push-button service deprives the patient of this and in effect makes him do for himself what he is paying to have done for him.

The basic function of a hospital is nursing care. The nurse must never be completely removed.—**Thomas P. Langdon,** Maffly and Langdon, Hospital Consultants, Berkeley, Calif.

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In an effort to solve the problem of how to keep patients in closer touch with the nurses, we designed a circular nursing unit. Every room is across from the nursing station; the station is in the middle and the rooms are in a circle around it.

One problem was deciding how to make the best use of pie-shaped rooms. We hesitated at first at putting beds against the outside wall where patients could not look out the window. However, interviews with patients brought out the fact that most of them are not interested in looking out but in looking in and seeing what is happening in the corridor. This is particularly true of the acute nursing patient.

TV sets are suspended from the ceiling over the bath and closet area and are controlled from the beds with a cubicle speaker. Cubicle curtains come down between the two beds in such a way that each patient still gets light from two windows and has, in effect, a private room.

The windows are paneled with 12′ vertical louvers that can be adjusted by the patient so he can open or close the window, or let in just as much light as he wishes. They eliminate the need for any draperies or blinds in the room.—**James S. Moore,** Pereira & Luckman, Architects, Los Angeles.

* * * * *

Planning democratically, analyzing each activity carefully, and inviting reactions from all staff members before building, is the best way to promote flexibility and roominess in nursing units. Practical preplanning enables nurses to contribute many ideas to improve the area in which they will be working.

The nursing unit should be ample, with plenty of space for working where patients and visitors cannot see. Other things to be considered include adequate recreational space, a separate dining room for convalescent patients, and the continuity of patient care—that is, whether night nurses care for more patients and thus need a larger nursing station.—**Alma K. Catherwood,** Chairman, Steering Committee, Division of Nursing Service, California League for Nursing, Fresno, Calif.

Melvin C. Scheflin, executive secretary, Association of Western Hospitals, with Mrs. Alfred E. Maffly, wife of the outgoing president.

* * * * *

As a recent hospital patient, I believe too much effort is spent on making the hospital room look more homelike. It cannot be done. The average patient asks only for a room that is uncluttered, clean, efficient, and reasonably attractive.

Too many hospital rooms are cluttered with furniture which interferes with nurses, cleaning women, and visitors. Flower stands, dressers, and armchairs should be eliminated if there is not room for them. There are often too many windows in the room; sometimes they are not caulked tightly enough, and wind blows through.

If rooms must have individual temperature controls, they should be rugged enough so that the patient isn't either too warm or too cold. Toilets and lavatories should be in every room but separated, so that both can be used simultaneously by patients and employees.

Deep research is needed by psychologists to find out more about what the patient wants in a hospital room.—**Everett W. Jones,** Hospital Consultant, Ft. Myers Beach, Fla.

Discussion

Q. What is the best size for a nursing unit?

MR. JONES: There isn't any one size; economy is the only standard. As you go up in size, however, you should realize that you do lose personal contact between nurses and patients.

Q. Is any work being done on improving the design of small hospitals in isolated communities?

MR. COOGAN: Lots of work is being done, although most California counties have been accommodated by now. The only difference in many of these hospitals is that they concentrate mostly on emergency services rather than on O.B. and surgical facilities. Emergency electrical services, for example, are very important. And some hospitals are being designed by doctors in the community who are adding wings for their offices. In a limited way, these serve as outpatient clinics.

Above: Sister St. Rogata, O.R.S., and Mrs. Dorothy Manson, assistant O.R.S., Oak Park (Ill.) Hospital, are caught by the TOPICS camera just before they board a bus for the Conrad Hilton Hotel to view the technical and commercial exhibits.

Nurses Map Goals, Discuss TB Care, Disaster Skills

If nursing schools are to meet the growing demand for nurses, enrollments in basic college programs in nursing must expand by 30,000 to 40,000 a year by 1970 and hospital and junior college programs, by 10,000 to 30,000 a year, according to a study presented at the National League for Nursing convention held in Chicago. Attendance was 7,228. Abstracts of some of the papers follow.

Projected Goal is 18,400 Annual Graduates by 1965

Existing Schools Can Expand Considerably

If we are to reach our goal of 300 nurses per 100,000 population, by 1965 our master's degree programs should be graduating each year 5,200 nurses who are prepared to assume leadership positions. Last year they graduated 549. Annual graduates from baccalaureate programs should number 13,200 by 1965. In 1956, there were only 4,725 graduates.

Financial assistance for nurses who undertake graduate study has started to come from nurses' educational funds, the NLN fellowship program, and the federal government, which has granted $2,000,000 for students preparing for administration, supervision or teaching of nursing.

Between the fall of 1955 and the fall of 1956, enrollments in master's degree programs in nursing rose 24 percent, and full-time enrollments increased 62 percent. These students were easily absorbed into existing graduate schools. These schools tell us they could accommodate enough full-time students to yield 1,400 annual graduations. With additional faculty and facilities, they could graduate another 2,800 a year, or 80 per cent of our goal.

In surveying expansion potentialities of baccalaureate programs, the schools indicated that with their present resources they could yield 1,000 more graduates per year. With additional faculty, classrooms, laboratories, and library and residence facilities, they could graduate another 3,300, or 10,500 students annually, again about 80 percent of our goal.

Consideration should be given to the establishment of a few more schools of nursing that could offer both graduate and undergraduate collegiate programs in nursing.

These points should be taken into consideration:

1. The distribution of collegiate facilities for nursing education among the four NLN regions is not in very good alignment with population distribution.
2. Consideration should be given to the type of new graduate programs that are to be developed.
3. Clinical facilities that are needed for student instruction should be properly utilized.—**Elizabeth V. Cunningham,** Publications Consultant, NLN Division of Nursing Education, New York City.

Amount of Professional Care Influences Patient Satisfaction

60 Hospitals Measure With PHS Checklist

The amount of total nursing hours provided per patient per day does not affect the amount of patient satisfaction with nursing care, but the amount of **professional** nursing care provided does have a strong positive influence on satisfaction. Ages of patients and personnel have a definite relationship to the amount of satisfaction with patient care. Older patients and personnel are generally more satisfied than are younger ones.

These findings were indicated on checklists developed by the Division of Nursing Resources, U.S. Public Health Service, to help hospitals improve patient care through better understanding of the patient's needs. A total of 8,000 forms from patients and 12,000 from personnel were returned.

Sixty general hospitals participated in the study. The dependent variable was satisfaction with nursing care as measured by the checklists. Independent variables were total hours of nursing care available, hours of professional nursing care available, size of hospital, and ownership of hospital.—**Faye G. Abdellah, R.N., Ed.D.,** Chief, Nursing Education Branch, Division of Nursing

(Continued on next page)

Resources, U.S. Public Health Service, Department of Health, Education, and Welfare, Washington, D.C.

Must Teach Disaster Skills While Nurse is Student

Sections of Improvised Hospital Shown in Mobile Exhibition

Disaster skills must be taught while the nurse is still a student. Formal instruction should be followed by a good inservice education program in the hospital.

We have set up a mobile hospital exhibition consisting of 12 sections of an improvised hospital, with the functions of each section fully explained. Since September 1956, 13,300, including 10,000 nurses, have attended lectures of this mobile unit.

In the disaster area, a nurse should have skills necessary for treating large groups of people. Skills for directing a large number of volunteers must be strengthened. She should have knowledge of the physical facilities in which she would work, a plan for transportation, and knowledge of where she can obtain help.

Life-saving technics must be administered for a large number of injuries that happen simultaneously. There should also be a reinforcement of communicable diseases education. — **Lillian Howell, R.N.,** Consultant Nurse, Office of Medical Defense, New York State Department of Health, Albany.

Tuberculosis Nursing Part of Texas School's Curriculum

Included in Basic and Degree Programs

Tuberculosis nursing is included in both the basic nursing program and the degree program, for graduates of diploma courses, at the University of Texas School of Nursing.

The course for graduate nurse students includes 40 hours of lectures and conferences taught over a period of eight weeks, with 10 hours of clinical practice per week.

The course in the basic program is taught in the senior year, following experience in all clinical areas except public health. It consists of 30 hours of lectures and conferences given in a four-week period, with 25 hours of supervised clinical practice per week. The unit on tuberculosis in childhood is omitted from the course for the basic students because this experience is provided in pediatric nursing.

Nurses pictured below extinguish flames which enveloped "patient" during demonstration of how to combat fire dangers in operating rooms. Forty-five seconds following the explosion and outbreak of fires, patients were moved to rooms on a lower floor.

The student plans, gives, and evaluates comprehe nursing care for one or two medical or surgical pati Additional clinical experiences include observation clinic services and of a public health visit, field trip community agencies, and conferences with profess workers.

Public health nursing experience, following tubercul nursing, affords opportunities to give care to tubercul patients and their families in the home.—**Bessie Ne** R.N., Instructor, Medical and Surgical Nursing, Univer of Texas School of Nursing, Galveston.

QUESTION AND ANSWER PERIOD

A panel consisting of Gordon A. Friesen, presid Gordon A. Friesen Associates, Washington, D.C.; Col. Elizabeth L. Breitung, R.N., nursing methods analy Army Nurse Corps, Washington, D.C.; Herluf V. Ol Jr., assistant director, Rhode Island Hospital, Provide Jessie Scott, R.N., M.A., nursing consultant, U.S. Pub Health Service Division of Nursing Resources, Depa ment of Health, Education, and Welfare, Washing D.C., and Ruth Sleeper, R.N., M.A., director, school nursing and nursing service, Massachusetts General H pital, Boston, discussed new ideas for old staffing pro lems. Part of the discussion follows.

Q. How does a maximum care unit function?

MISS SLEEPER: In a maximum care unit, you ha to determine what is maximum for whom. Is it co plete care for 24 hours? What is your purpose a philosophy for setting up such a unit? The unit has t be operated under the joint efforts of medical, admini tration, nursing and other related groups. There m be a constant re-evaluation of unit's purpose.

Q. How are private duty nurses used in a maxim care unit?

MISS SLEEPER: The private duty nurse is used o the same basis as she is in any other unit. She receive the same pay.

Q. What is your special care unit like?

MR. OLSEN: The 16-bed unit takes both private an ward patients. We strongly try to get the people o the unit. We feel the patient is getting better patie care. However, the doctors are doing more surger than they would normally do.

Q. How are your linens done?

MR. OLSEN: A linen committee meets once a month Linens are supplied daily on the ward. Linen replace ment is taken care of by a member of the laundry de partment. The storage department checks the inventor every night. The head nurse can raise the par if she feels the linen supply is too low.

Q. How many categories for patients do you have in the Army Nurse Corps?

LT. COL. BREITUNG: Category one requires intensive nursing care and a great deal of assistance. Category two needs moderate nursing care and some assistance. Cate gory three gets minimal nursing care, in the ward, an the patient is ambulatory. Category four has supportive nursing care and the patient is convalescent.

Q. How many hours of nursing care are required in th different categories used in your method?

Genevieve Irwin, Lenox Hill Hospital, New York City; Diantha Welles, Lawrence and Memorial Associated Hospitals, New London, Conn., and Pat Cabble, also of Lenox Hill Hospital, take in some fresh air before the afternoon session, National Student Nurses' Association.

LT. COL. BREITUNG: In category one: 2.7 in professional nursing care; 2.3 by medical technicians, and 1.21 by ward clerks, making a total of 6.21 hours of nursing care. There are 2.68 hours of nursing care in the second category, broken down into 1.01 professional care, 1.06 by medical technicians, and .61 ward. The third category has the following hours spent in nursing care: .54 for professional nurses; .55 for medical technicians, and .38 for ward clerks, making a total of 1.47 hours. The fourth category, with 1.28 hours of nursing care, includes .39 in professional nursing, .52 for medical technicians, and 37 for medical and ward clerks.

Q. How can you save the nurse's time?

MR. OLSEN: If nursing is to provide leadership, it is up to the administration to provide an atmosphere where this can be accomplished. This can be done by patient-care meetings on various specialties, where recommendations are accepted from the nursing department. Try to get the non-nursing functions delegated to other departments. The nursing supervisor, as the coordinator of patient care, can initiate meetings where dietary, housekeeping and other departments are invited.

All Freshmen Admitted to Basic Educational Program

Graduate of Associate Program Comfortable In Role of Bedside Nurse

The associate degree program has undergone many changes. All freshmen students without previous nursing experience are now admitted to one basic program. Prior to September, 1956, students were admitted separately to the associate and the bachelor's degree programs.

Summer sessions have been eliminated. To offset this loss, the school year was extended from September 1 to June 30. This makes it possible to include in each of the two major clinical courses six 40-hour weeks of clinical experience.

Learning experiences in nursing have been combined into four courses, two taught each year.

The sequences of learning experiences are: fundamentals of nursing, nutrition, organic chemistry, and anatomy and physiology—prerequisites to the maternal and child health nursing course—are taught in the fall term of the first year. Interpersonal relations, a prerequisite to psychiatric nursing, is taught concurrently with maternal and child health nursing in the spring term of the first year. Principles of sociology, taught concurrently with psychiatric nursing in the fall term of the second year, continues through the spring term. Medical and surgical nursing is taught in the spring term of the second year.

Students moving from the fundamentals course into maternal and child health nursing need much individual instruction. There have to be at least three instructors for 12 students.

Our program has 20 graduates, 19 of whom have written the licensing examination and passed it. The percentage of graduates who received scores of 600 or over in subjects tested are: 31 percent in psychiatric and surgical nursing; 27 percent in obstetrical nursing; 37 percent in pediatric nursing, and 42 percent in medical nursing.

The graduate of the program is prepared to do nursing, and is comfortable in the role of bedside nurse.—**Ella Stonsby, R.N.,** Dean, Rutgers University School of Nursing, Newark, N. J.

Disaster Nursing Included In College Curriculum

Try to Give Understanding Of Impact on Community

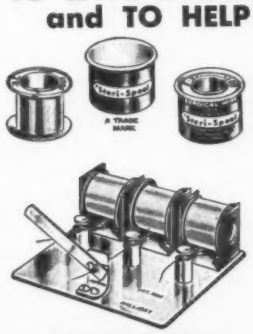
Disaster nursing education at Union College, Lincoln, Nebr., attempts to give students an understanding of a major disaster's impact upon a community, and to prepare them to function as professional nurses in a civil or military emergency.

Rather than introduce a specific course labeled "disaster nursing," the curriculum was revised to include knowledge, skills, and attitudes that would be of value in any minor disaster.

Students formerly gave nursing care to medical and surgical patients, and had a course in first aid to the injured. Now first aid is integrated into medical and surgical nursing instruction, and disaster aspects are added. When a student studies nursing care of a burned case in a hospital, a discussion period is held to determine

(Continued on next page)

TO SAVE OPERATING ROOM TIME and TO HELP THE SURGEON



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what first aid care should or could have been given. Discussion continues into problems of managing the mass care of burned cases. Students learn the necessity of evaluating the victim's likelihood of survival, and the need for selecting cases for care.

Alternate methods of artificial respiration are taught because standard methods may not always be possible. The forearm rocking method is taught for use on babies. In all, the student learns seven methods of helping a victim breathe.

The curriculum includes ways of maintaining health services under disaster conditions.

Students learn how to improvise equipment from cardboard boxes, tin cans, and newspapers to care for the sick and injured in a home or improvised hospital.

To increase their skills in teaching and directing trained and semi-trained workers, students take instruc training courses of the American Red Cross in h care of the sick, in mother and baby care, and in aid to the injured.

Final work in disaster nursing is given in the se year. With the community's aid, students organi mock bombing raid, set up a medical aid station, and improvised hospital to care for over 100 simula casualties running the whole gamut of injuries. T coordinate the services of physicians, surgeons, dent veterinarians, nurses, clergymen, firemen and p officers.

The disaster nursing program tries to teach stud to think, and to make optimum use of human and mat resources.—**Alice E. Smith, R.N.**, Director, Union Col Department of Nursing, Lincoln, Neb.

Mid-West Group Told

Community-Hospital Cooperation Necessar

Disaster planning, personnel shortages, development of hospital-community relationships, and the hospital of the future were topics at the recent 29th Mid-West Hospital Association meeting in Kansas City, Mo. More than 2,500 attended.

Tol Terrell, AHA president-elect, said hospitals are becoming health and medical centers for all the community rather than for acutely ill patients only. Expanding research and clinical programs must not be assessed against the bed patient only, through higher daily rates, he warned.

Local hospitals that work cooperatively on community needs, avoid costly duplication service, and plan together for unfilled needs, are the key to health progress, he also pointed out.

Charles U. Letourneau, M.D., director, Northwestern University School of Hospital Administration, Chicago, forecast underground hospitals; pre-processed frozen foods that can be stored, placed under microwaves for 30 seconds, and served; television receivers at nursing stations for observation of patients' needs; temperature recording on graphs by electronic impulses, and continuous recording of heartbeat and pulse rate electronically.

"How to Develop Good Hospital Community Relationships" was discussed by a panel consisting of the Rev. G. L. DeLapp, bishop, Reorganized Church of Jesus Christ of Latter Day Saints, Independence, Mo.; Ralph Coffey, M.D., director, surgical department, Kansas City (Mo.) Municipal Hospitals; Tol Terrell, administrator, Shannon West Texas Memorial Hospital, San Angelo, Tex.; Mrs. Cecil Snyder, board of trustees, Kenosha (Wis.) Hospital, and James E. Hague, executive editor, *Hospitals*, Journal of the American Hospital Association.

They pointed out that hospitals sometimes act as if the public should be cultivated only when a new drive for funds is anticipated. Good public relations begin with admitting clerks, and interest in the patient's welfare should start with them and extend to the patient from every employee and staff member. Advance planning by doctors the incoming patient would avoid meaningless delays misunderstandings.

Reassurance can be a bigger help to a worried pat than tranquilizing drugs, in many instances, the p told delegates.

New officers elected by the association were: Br L. Twitty, administrator, Hillcrest Medical Center, Tul Okla., president; James G. Carr, Jr., administra Memorial Hospital of Natrona County, Casper, Wy president-elect; Carlos J. R. Smith, administrator, He (Ark.) Hospital, treasurer; and Herbert A. Anderson, ministrator, Lincoln (Neb.) General Hospital, delegate- large.

Officers, Mid-West Hospital Association, are (l. to r.): Hubert Hughes, administrator, General Rose Memorial Hospital, Den retiring president; Bryce L. Twitty, administrator, Hillcrest Medi Center, Tulsa, Okla., president, and James G. Carr, Jr., admi trator, Memorial Hospital of Natrona County, Casper, Wy president-elect.

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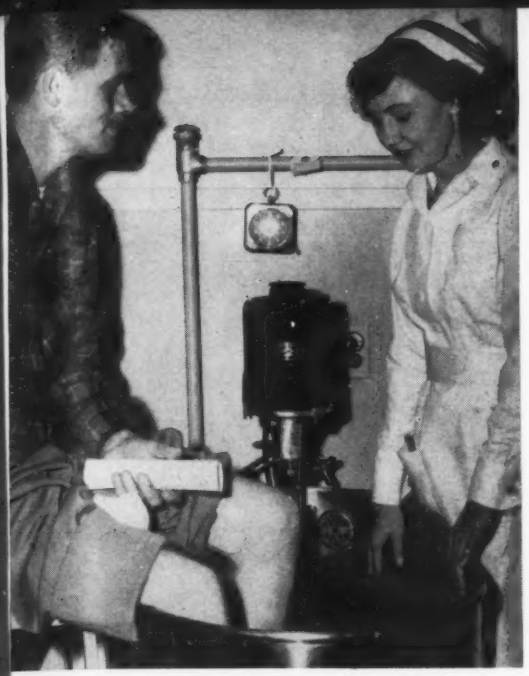


gure 1. Promptly on healing, individually prescribed and super-ed physical activities are used to secure a properly conditioned d shrunken amputation stump. The entire body is treated with irlpool and other physical therapy activities to obtain proper uscle and body tone.

Navy Center Research Makes Amputees' Future Ever Brighter

Over 7,000 amputations, with no deaths resulting, is the record of the Oakland Naval Center, which is constantly making improvements in amputee care.

By Dorothy W. Errera, R.N.

OFFICIAL U.S. NAVY PHOTOGRAPHS

World War II presented the Naval Hospital at Mare land with 3,000 amputees. "There they were, and mething had to be done for them," says Capt. Thomas Canty, chief of the amputee service. Twelve years ter, in a modern building at the Oakland Naval Hospital, e can see the impressive evidence of the results of a dicated and continuous program of research and de-lopment aimed at "doing something" in a field dormant r many years. Dr. Canty and many of his originally signed associates have worked together in the first mputation Rehabilitation Center established in this untry.

They have so successfully duplicated the mechanics d functions of the human musculo-skeletal system in eful prostheses for amputees that extremities can be stored to usefulness regardless of the degree of utilation.

Heretofore, prostheses determined that amputations be ne at levels indicated by the type of artificial limb ailable rather than the true extent of injury. Today, ery amputation is performed "to save as much as ssible"—a philosophy made possible by the vast ar-amentarium of the Amputee Center.

From the Korean War came 2,000 amputees. The pres-t peace-time census runs from 25 to 40 patients, with average hospital stay of three months.

In the first phase of the amputee program at Oakland, e patient is given over-all medical and surgical care. ransfusion and chemotherapy are major factors in pre-erative preparation. The Naval Center has had over 00 amputations with no death due to the amputation. is felt that the care given the pre- and postoperative ase of the patient's course is responsible for this ccess.

All stumps require at least two operations for revisions med at making them most receptive for prostheses. e length and muscular power of the stump are im-portant in utilizing prosthetic devices with suction sockets, and surgical technics are directed at providing the amputee with a stump of minimal scarring and one in which the bone has been treated to provide a conical-shaped stump; at avoiding ring sequestrum, aseptic necrosis, osteoma, and spur formation.

As the patient's wounds heal and he becomes ambulatory, physical training and progressive exercises are prescribed (Figure 1). The amputee attends classes, open forums, round tables, discussions—all intended to help in making the adjustment to his handicap. When the stump is well healed and shrunken, he is ready for the fitting of his prosthesis.

Mechanics, materials study, modern plastics, and modern fabricating technics are then put to use to provide the amputee a properly fashioned, well-fitting, comfortable, and cosmetically attractive prosthesis (Figure 2).

(Continued on next page)

Figure 2. Comfort and function are the major objectives for each amputee. Navy-developed limb shown features functional ankle joint, laminated plastic shin, forged aluminum hinges, and plastic stump socket of soft, pliable construction.

Figure 3. Training in use of leg prostheses is given by instructor who is also leg amputee. Beginning with simple weight transfer between sound and artificial leg, gait training is gradually intensified to include ramps, stairs, curbs, uneven terrain, and a variety of walking surfaces. With proficiency, activities include changing pace, stepping over objects, dancing, running and skating.

REHABILITATION continued

The first plastic shin (Figure 3), was developed at the Navy Center in 1943. Previously shins were fabricated expensively and laboriously of wood. Today they are made of cotton stockinette and plastic (polyester resin) by technics which could be stepped up to produce large numbers by relatively untrained personnel in case of a national catastrophe involving large numbers of amputee casualties.

Figure 4, above-knee suction socket prosthesis. In ankle unit, plantar and dorsal flexion, as well as lateral motion and transverse rotation, take place normally during walking cycle. Lightweight shin is of plastic laminated structure of unusual strength. Artificial knee employs Navy Variable Cadence Unit, which applies terminal deacceleration on either end of the swing phase. Stump socket of wood employs special valve to maintain required air pressures.

Suction sockets are used routinely on above-knee amputees, eliminating cumbersome, heavy pelvic belts, hip hinges, shoulder harnesses, etc. About 80 percent of these amputees are successfully fitted with these sockets (Figure 4). The suction socket is fashioned through series of maneuvers from a plaster impression of the patient's stump to the final covering with a nonto inexpensive plastic of flexible texture, which is easy keep clean and does not absorb perspiration, which

Figure 5. The bilateral below-elbow amputee shown above lost b arms as result of an explosion. After 13 weeks of fitting and oth rehabilitative procedures, including training, his proficiency was su that his pilot's license was renewed and he resumed his job as fer boat captain on San Francisco Bay.

cause unpleasant sequelae. Suction sockets today ar made with closed ends which encourage proper weight bearing through the hip joint instead of the ischia tuberosity.

The center can turn out a leg in a day, but no limb is considered finished until the patient is able to use i functionably and comfortably. Dr. Canty estimates tha information collected from the experience of at leas 100 patients wearing a single type of device for a yea is necessary for checking on the efficiency or success o improvements in prosthesis design.

The developments of this unique center include hydraulic fixture in hip prostheses to keep the knee fro buckling, and a functional ankle joint which allows motio simulating closely that of the natural ankle.

The full-length leg brace, with a knee lock whic could be disengaged for sitting but which forced th wearer to walk with a stiff, straight leg, has been r

esigned so that the axis of the knee joint is behind the natomic weight-bearing line and knee flexion is possible ith each stride. The added disability from the im-obilized knee joint is eliminated. Blueprints of this race are available to any brace-maker.

Prostheses developed for carpometacarpal disarticula-ions make use of the normal wrist function. Cineplastic echnics provide below-the-elbow amputees (Figure 5) ith means for efficient and natural operation of their rostheses—all within their own neuromuscular command. he majority of hand amputees prefer hooks for utility, ut interchangeable cosmetic hands (Figure 6) are also vailable.

Figure 6. Individually colored plastic gloves and finger restorations attain cosmetic acceptability. Devices provide non-functional cover for partial hand, or full cover for articulated artificial hand mechanism developed by the Navy laboratory. Resulting combination is lifelike in appearance and in useful function.

The program of the center does not stop with the fabrication of the prosthesis, but continues through the training of the amputee in the use of it and guidance of his physiological adjustment to it. Prevocational training and educational programs are utilized to determine the patient's qualifications for work. In many instances, vocational training is started while the patient is still hospitalized (Figure 7). Amputees resume their former jobs or are guided to jobs which they can perform as decided assets to the employer.

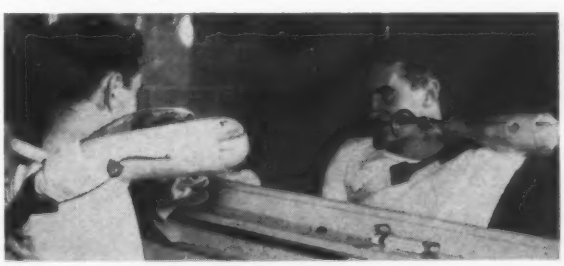
The specialized know-how of this well-integrated organization is disseminated through classes held for foreign representatives, GI students, and Navy personnel. They encompass basic anatomy and physiology as well as the intricacies of fitting and fabrication of limbs.

Figure 7. Prevocational counsel and advisement is individually provided, based on optimistic and practical capabilities. General Educational Development tests and facilities of the U.S. Armed Forces Institute are employed. Educational facilities local to the hospital are also frequently utilized.

Research is continuous, and improvements in appliances are being constantly made. Future plans include a program of study of the physiology of the musculo-skeletal system.

The statistics of one study show what is possible when a program of this nature is allowed continuous and concentrated development. Only six percent of 402 patients discharged over a three-year period are unemployed or not using their prostheses. The remaining 94 percent are successfully employed in all types of jobs—from accountants to zoologists.

Training in use of arm prostheses is provided daily by instructor who is arm amputee. Navy-Fitch prosthesis, developed by the laboratory and now commercially available, extends functional use of above-elbow amputation stump. Training begins with acts of daily living, then is extended to operation of everyday devices including typewriter, telephone, doors, switches, faucets, and many others. Special devices permit participation in bowling, tennis, hunting and fishing.



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Hospital Business Operation

Eighth in a series on hospital organization, based on lectures given at meetings of the Association of Western Hospitals and allied state groups

By John H. Gorby*

Admissions and Discharges

PART II

This is the second part of a two-part article on admissions and discharges. In the first installment, which appeared in the May issue, Mr. Gorby discussed types of admissions, admission procedures, and financial arrangements.

● Forms are important in effective admitting office procedure. Exhibit 1 shows the first sheet of an eight-part admission form. The form is a snap-out carbon design, and the other seven copies are on 5 x 8 stock, so that some copies can be filed in visible index racks. The remaining copies are distributed to:

- Business office
- Nursing office
- Admitting office
- Medical records
- Switchboard
- "Gray Ladies"
- Clergy file.

Certain items of information on the copies for switchboard, "Gray Ladies," and clergy file were eliminated by designing those copies with items crosshatched.

Another form is the pre-admission questionnaire (Exhibit 2). Use of this form enables the admitting clerk to complete the admission records for scheduled elective patients at a time other than the period of her peak work load. The item numbers shown in the bottom section of the form "For Maternity Patients Only" can be modified to correspond with the official birth certificate of the state in which the hospital is located.

There should be a standard assignment form prepared with the hospital name imprinted. In all cases in which the patient presents insurance coverage other than Blue Cross, the hospital should insist that benefits payable be paid direct to the hospital. If the patient refuses to sign an assignment, the best method is to treat the case as any non-insurance case and follow the hospital's customary admitting practice.

It is suggested that the assignment form be executed in duplicate. One copy should be sent to the insurance company immediately upon the patient's admittance. This very effectively serves as a notice to the company.

STAFFING AND WORK LOADS

Great care should be taken to obtain admission personnel who are experienced in dealing with people. There is a trend toward the use of nurses as admission officers.

Most hospitals have restrictions on hours of admissions, except for emergencies. In order to make such rules work, someone other than the patient's physician must be able to distinguish an emergency from an elective admission of convenience.

Many hospitals are formally or informally attempting to assign patients to nursing units according to the nursing requirements of the patients or the work loads of the units. In such a program a thorough knowledge of the hospital's nursing problems and the patient's needs is required by the admissions office. The necessity for this knowledge will increase as patients are assigned more and more to accommodations according to their requirements rather than their ability to pay. If the use of intensive nursing units increases, the need for nursing knowledge in the admissions office will also increase.

There are many competent graduate nurses who, for various reasons, cannot meet the arduous demands of general-duty nursing but who can effectively perform the functions of the admission officer.

For large hospitals, employing several clerks, care should be taken to match personnel hours to work loads. A factor can be developed, by time studies or other methods, to indicate the average time spent on processing each admission. By plotting on a single graph the average number of admissions and the average number of admitting clerks for each hour, the time standard can be applied to determine whether a balance has been attained between staff assignments and work load.

Problems of unbalance which are found may then be solved by adjusting staff assignments, hours of work, or policies regarding admitting hours. Exhibit 3 shows a typical chart of a daily work-load analysis.

It is a cheap investment to procure at least part-time help and cover the front office seven days a week. Many hospitals which have complained of growing accounts receivable have had no one on duty in the front office on Sunday, the day that many patients prefer to go home. A part-time person in this capacity will more than pay for himself, even if the individual is not specifically trained in collections. College girls in their junior or senior year are a good potential source of personnel.

PHYSICAL FACILITIES

Even the smallest hospital should provide a private admitting room. Many persons are sensitive about giving information of a highly personal nature in the presence of others.

(Continued on page 38)

*Administrator, La Mesa (Calif.) Community Hospital, and former chairman, Community Hospital Section, Assn. of Western Hospitals.

The amount of space needed is related to the work load and to the staffing pattern, as well as to the admitting practices. In general, the problems encountered in t office's physical facilities are overcrowding and lack facilities for conducting private interviews.

Figure 1

ADMISSION RECORD

PATIENT INFORMATION

LAST NAME, FIRST, MIDDLE | SEX | RACE | DATE & HOUR ADMITTED | ROOM NO. | RATE | HOSPITAL NO.

ADDRESS, PHONE NO. | EMPLOYER

AGE | BIRTH DATE | BIRTHPLACE | MARITAL STATUS | RELIGION | OCCUPATION

FATHER'S NAME AND AGE | BIRTHPLACE | MOTHER'S MAIDEN NAME AND AGE | BIRTHPLACE

RESPONSIBILITY INFORMATION

HOSPITAL INSURANCE PLAN, COMPENSATION OR INSURANCE COMPANY | POLICY NO.

ASSURED'S NAME, ADDRESS AND RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY'S NAME AND ADDRESS | PHONE NO.

RESPONSIBLE PARTY'S EMPLOYER'S NAME AND ADDRESS

PERSON TO BE NOTIFIED IN AN EMERGENCY – NAME AND ADDRESS | PHONE NO. | RELATIONSHIP

HOSPITAL INFORMATION

ADMITTING DOCTOR | PHONE NO. | SERVICE DIVISION | REFERRING DOCTOR

ADMITTING DIAGNOSIS | OBJECT TO NEWSPAPER REPORTING?

DATE OF PREVIOUS DISCHARGE AND NAME THEN | DATE TRANS. | TO ROOM | RATE

LAST NAME, FIRST | DOCTOR | ROOM NO.

TO BE COMPLETED BY PHYSICIAN

FINAL DIAGNOSIS | CODE NO.

COMPLICATIONS | CODE NO.

OPERATION (S) | DATE (S) & CODE

SURGEON | ASSISTANT

CONDITION ON DISCHARGE | CAUSE OF DEATH | AUTOPSY

☐ RECOVERED ☐ IMPROVED ☐ UN-IMPROVED ☐ DIAGNOSIS ONLY ☐ EXPIRED | ☐ YES ☐ NO

DATE & HOUR DISCHARGED | PATIENT DAYS | THIS RECORD REVIEWED AND APPROVED M.D. | DATE

All too frequently, the admitting functions are performed in a single small office into which may be crowded, during peak periods, the admitting officer, one or two admitting clerks, two or three desks, five or six chairs, and as many as two or three patients and four or five relatives.

Because of the intimate nature of the information desired, the office should provide privacy. Interview rooms or cubicles are desirable. The interviewing rooms may serve a dual purpose for admitting and credit interviews.

(Continued on page 41)

Figure 2

PRE ADMISSION QUESTIONNAIRE

TO		FROM ADMITTING SECRETARY	DATE
DOCTOR	SERVICE DIVISION	EXPECTED ADMISSION DATE	ADMITTING HOUR

A reservation has been requested for you. To save you inconvenience at the time of your admission, will you kindly complete and return this questionnaire AS SOON AS POSSIBLE.

This information, which will be held in the strictest confidence, is necessary to this hospital in order that certain medical and legal requirements be met.

CONFIDENTIAL INFORMATION – FOR HOSPITAL USE ONLY

1. PATIENT'S FULL NAME			2. SEX / 3. RACE
4. STREET ADDRESS	5. TOWN		6. TELEPHONE NO.
7. AGE / 8. BIRTH DATE / 9. BIRTHPLACE (STATE OR COUNTRY)	10. MARITAL STATUS		11. RELIGION
12. OCCUPATION	13. DO YOU OBJECT TO NEWSPAPER REPORTING? (YES OR NO)		
14. PATIENT'S FATHER'S NAME (WHETHER LIVING OR DECEASED)		15. AGE	16. BIRTHPLACE
17. PATIENT'S MOTHER'S FULL MAIDEN NAME		18. AGE	19. BIRTHPLACE
20. NAME OF HOSPITAL INSURANCE PLAN, COMPENSATION OR INSURANCE COMPANY			21. POLICY NO.
22. STREET ADDRESS			23. TOWN
24. NAME AND ADDRESS OF POLICY HOLDER			25. RELATIONSHIP TO PATIENT
26. POLICY HOLDER'S EMPLOYER'S NAME AND ADDRESS			
27. NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT OF BILL			28. TELEPHONE NO.
29. RESPONSIBLE PARTY'S EMPLOYER'S NAME AND ADDRESS			
30. NAME OF PERSON TO BE NOTIFIED IN AN EMERGENCY	31. TELEPHONE NO.		32. RELATIONSHIP
33. IS THIS A READMISSION TO WARREN GENERAL HOSPITAL ☐NO ☐YES	34. IF "YES" GIVE DATE OF DISCHARGE AND NAME THEN		
35. TYPE OF ACCOMMODATION DESIRED – IF AVAILABLE ON DATE OF ADMISSION ☐PRIVATE ROOM ☐SEMI-PRIVATE ROOM ☐WARD			

FOR MATERNITY PATIENTS ONLY
THIS INFORMATION REQUIRED FOR FILING THE BIRTH CERTIFICATE WITH THE STATE DEPT. OF HEALTH

FATHER OF CHILD

7. FULL NAME	8. COLOR OR RACE	9. AGE–AT TIME OF THIS BIRTH
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	11A. USUAL OCCUPATION	11B. KIND OF BUSINESS OR INDUSTRY

MOTHER OF CHILD

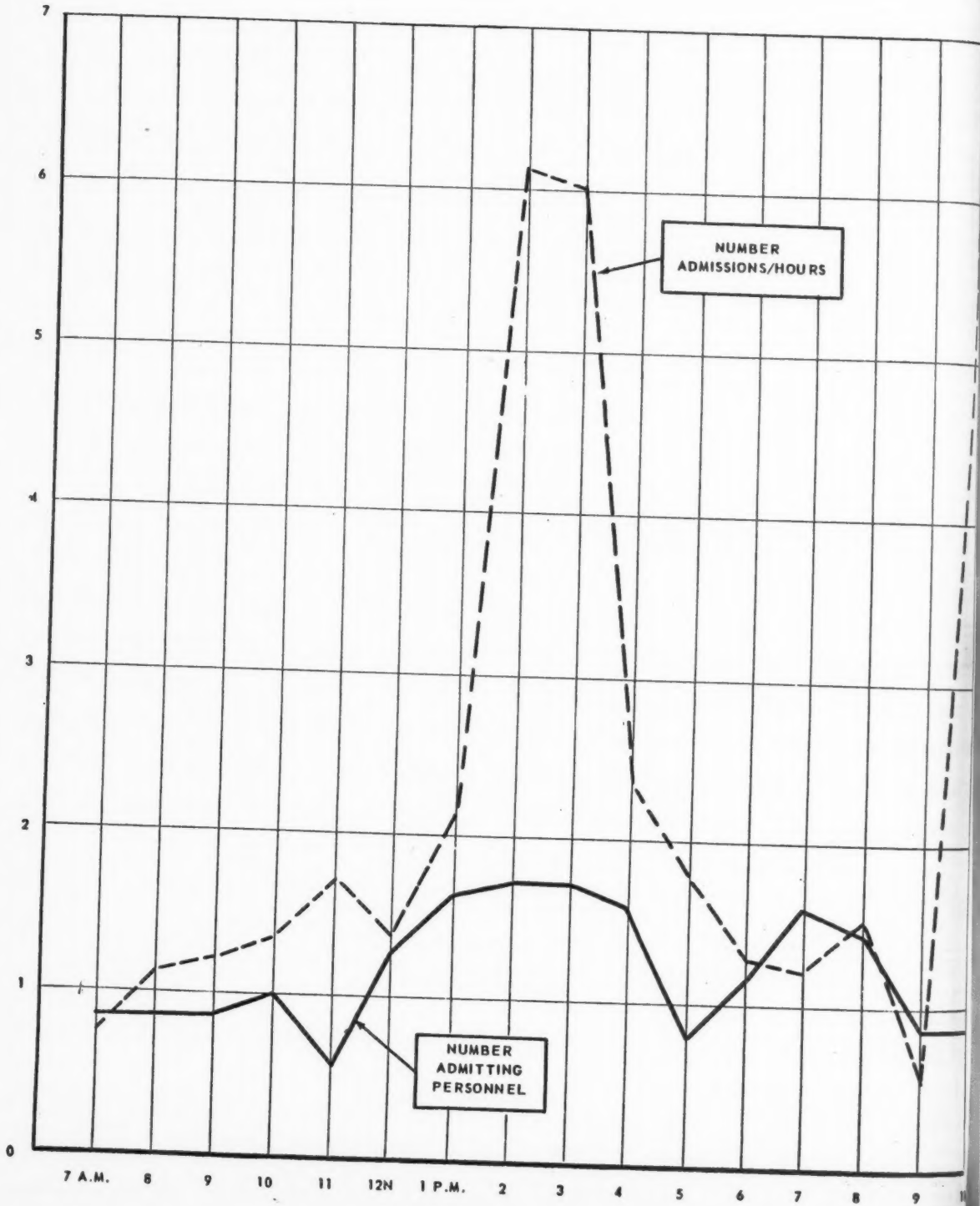
12. FULL MAIDEN NAME	13. COLOR OR RACE	14. AGE–AT TIME OF THIS BIRTH

15. CHILDREN PREVIOUSLY BORN TO THIS MOTHER – DO NOT INCLUDE THIS CHILD

A. HOW MANY OTHER CHILDREN ARE NOW LIVING?	B. HOW MANY OTHER CHILDREN WERE BORN ALIVE BUT ARE NOW DEAD?	C. HOW MANY CHILDREN WERE STILL BORN (BORN DEAD AFTER 16 WEEKS OF PREGNANCY)?

Figure 3

ADMITTING OFFICE – DAILY WORKLOAD ANALYSIS



(Continued from page 39)

DISCHARGE

The patient is always discharged by the physician. After the physician has ordered the patient discharged, the nursing service should do the following:

(1) Notify the business office.

(2) Secure the patient's clothes if they have been stored in a separate room. Check the clothes list with the patient and then have it signed at the time of actual discharge. If the clothes are kept in the room, this should be done by the nursing service and a note made on the chart that all clothes have been returned to the patient.

(3) In all instances the patient should be escorted in a wheel chair to the door or ambulance entrance where he is picked up by relatives. A very sound reason for this protection is that because of early ambulation and short hospital stays, patients today are not discharged in as top physical condition as they were 15 years ago. It may be several days after discharge until the patient has recovered strength enough to walk or otherwise move around unassisted, even though he has recovered from the condition requiring hospitalization.

BUSINESS OFFICE

The business office plays a very important part in the discharge of patients. Any efficiently-run organization has immediately available a complete bill for its customers or clients. The hospital should be no exception. It should avail itself of the many effective methods for controlling "late charges," and reduce these charges as much as possible.

The responsibility for patient valuables lies with the business office. The patient should be notified upon admission that the hospital assumes no responsibility for valuables unless they are turned over to the custody of the hospital. A notice with similar wording should be posted in each room. This has the legal effect of limiting liability.

If the patient is covered by insurance, the hospital should have determined while the patient was in the hospital whether the insurance company is reputable, if possible. The hospital should have obtained at the time of admission an assignment authorizing the insurance company to pay the hospital direct. At discharge the hospital should collect the difference between the amount allowed by the company and the hospital retail billing.

If the patient is a Blue Cross subscriber, the mailing form which the hospital forwards to Blue Cross indicates the coverage. In most cases, the patient's bill is paid in full. There may be a small additional charge on medication. This is an invaluable opportunity for hospitals to spread the good word on Blue Cross. The patient should be told something like this: "How fortunate that you are prudent enough to arrange a prepaid health and hospital plan like Blue Cross. You have received the finest medical care in the world at a daily cost of pennies."

The bill should be explained to the patient carefully and clearly. The cashier should bear in mind that many patients have no concept of the tremendous cost involved in modern medical treatment. If a balance is due after Blue Cross or commercial insurance payment is figured, it should be emphasized that the insurance paid a major portion, and that the patient might have secured full payment of the bill, had he chosen to pay higher premiums.

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Filipino Nurses Here for Clinical Preceptorship

A well-equipped laundry is adjacent to the lounge. Hard at w... are Alicia O. Yu (at ironing board), Hermenegilda Reyes, ... Anita de Vera.

• Fifteen Filipino nursing students were just recovering from their long plane ride from Manila and beginning to get acquainted with their new home when they welcomed the TOPICS photographer.

Home for the next year, and for a second year if they wish to stay, is the Georgetown University Hospital, Washington, D.C. All graduates of nursing schools in the Philippines, the visitors are taking a clinical preceptorship program at Georgetown, and will serve as supervisors and instructors when they return to the Philippines.

They are here under an exchange visitor program sponsored by the U.S. State Department. Additional students are at hospitals in other parts of this country. Georgetown has had four students previously, and is expecting 10 more.

Age range of the Georgetown group is approximately 22 to 32. All the students had some hospital experience in their homeland. They were carefully screened for participation in the exchange visitor program by the medical and nursing screening committee of the International Rotary Club of Manila, whose members are Gumarsindo Garcia, M.D., chairman; Rodolfo Gonzalez, M.D.; Herminio Velarde, M.D., and Jose Y. Fores.

Through the cooperative efforts of John Oppenheimer, director in the Philippines of Pan American World Airways, and Emil F. Klein, of Pan American's Washington sales office, these young women were brought to Geor... town for this program.

After consultation with Ethel Odegard, executive sec... tary, District of Columbia Nurses' Examining Board, ... rangements were made by the hospital for a clinical p...

Watching TV in the large lounge are Natividad L. Marcelo ... and Mercedes M. Manalac.

Pictured in the lounge with Sister Charl... Regina, assistant administrator, are (fro... row, l. to r.): Linda P. Dimaranan, ... Mercedes M. Manalac, Gilda R. Reyes, ... and Alicia O. Yu. Second row (l. to r.): ... Nelly D. Untalan, Rosita Paras, Natividad ... L. Marcelo, Pacita L. Blas, Sister Charl... Regina, Cecilia Ronquillo, Esther T. Fl... Ruby M. Catanes, and Anita de Ver... Back row (l. to r.): Iluminada R. Capistran... Antonia J. Ventura, and Andrea S. Dalip... The alert, friendly visitors volunteer... to take picture captions, which ... wrote down in accepted journalistic fashi... (left to right). They acquired th... knowledge in journalism classes back hom...

eptorship program for the Filipino nurses.

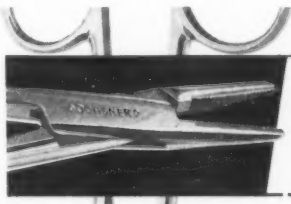
The students are practicing newer nursing skills and echnics brought about by the rapid advances in the treatent of medical and surgical conditions, and are becoming amiliar with the newer medicines used in research. They re required to write a paper in each of the four major ervices—medical, surgical, pediatric, and obstetrical nursng. Upon satisfactory completion of the course, each will eceive a certificate.

Above: A modern Pullman kitchen is in one corner of the students' lounge. The cooks shown here are Nelly Untalan (l.) and Cecilia Ronquillo.

Below: Iluminada Capistrano (l.) pours medication, while Andrea Dalipe prepares a syringe injection.

Above: With mementos of the Philippines close at hand, Pacita L. Bla (l.) writes a letter home, while Linda P. Dimaranan reads a magazine in one of the comfortable twin-bedded rooms in the modern nursing school residence.

Left: Stopping to say hello to patient are (l. to r.): Esther Pico, Ruby Catanes, Antonia Ventura, and Rosita Paras.



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John G. Steinle

Consultant's Corner

By John G. Steinle

• The series of articles by John H. Gorby on medical staff organization* has apparently stimulated a number of questions. The first three problems discussed this month relate to medical staff organization.

Q. Should the radiologist and pathologist be permitted a vote on the medical board?

A. It is assumed that the medical board constitutes a policy body of the medical staff. In a number of situations the medical board is composed of the officers of the medical staff and chiefs of the various services. In some instances the pathologist and radiologist sit with the board in an ex-officio capacity. In other instances they are members of the board by definition.

Both the pathologist and the radiologist are in a most enviable position for ascertaining and evaluating the general quality of medical care given in the hospital. Anything which would restrict or hinder the effective use of these specialists in influencing medical care should be discouraged. It is therefore recommended that the pathologist and radiologist be accorded full membership on the medical board.

Q. Our 175-bed hospital has the following departments: medicine, surgery, pediatrics, obstetrics—gynecology, radiology, and pathology. The two orthopods want to establish their own department. What is your reaction to this?

A. A separate orthopedic department should not be established. There is always a danger in the fractionalization of departments. The fewer the members of a department the more difficult becomes the exercise of objectivity in review of performance. For example, how can a two man department review performance?

Q. Members of the surgical staff have requested a dual responsibility over pediatric surgical patients. We are a 210-bed hospital. What do you think of this request?

A. We have observed a number of situations in which dual authority over pediatric surgical cases has been attempted. This arrangement usually causes more conflict than it avoids. The basic rule is that one service must be responsible for the patient. The pediatric specialty came into existence because of the unusual needs of children. The pediatrician is concerned with the total child; the surgeon is concerned about a specific area of the patient.

Considering all elements, psychological as well as physiological, that are involved in the care of the surgical pediatric case, we believe the over-all responsibility can more effectively be met by the pediatrician.

Medical policy for the pediatric nursing unit is geared to the special problems of children. Policy is set by the pediatric staff, and this staff has the responsibility of enforcing it. The surgeon obviously must see the pediatric patient and be responsible for his specific area, but the over-all responsibility should be that of the pediatrician, on the pediatric unit, both postoperatively and preoperatively.

I believe that it is bad practice to care for pediatric surgical cases anywhere except on the pediatric unit. All elements of this unit are geared to the needs of the infant. Instruments, needles, technics, nursing concepts, and rules are designed for this special patient.

Q. Where can we get a set of plans for a 25-30 bed hospital?

A. Floor plans are designed to meet the hospital's specific needs. The obstetrical load, the emergency work, the number of x-ray and laboratory ambulatory patients will vary tremendously between communities. Many small hospitals today are in financial trouble because these and many other factors were not taken into consideration in tailoring the hospital. Plans of other hospitals, or guide plans, must be used with a great deal of caution. They may provide information and stimulate ideas. They cannot be used as the basis of plans for your hospital.

The best plans that have been developed for guide purposes for the small hospital are those prepared by the Public Health Service for a 25-bed hospital. These can be obtained by writing to your State Hospital Facilities Program Agency. These agencies are listed on page 374 of the AHA Administrator's Guide Issue (*Hospitals*, August, 1956, Part II).

Q. What are the greatest stumbling blocks to hospital accreditation?

A. According to the Greater New York Hospital Association, the most common administrative deficiencies encountered in the first 100 surveys made by the Joint Commission on Accreditation of Hospitals in 1956, were in this order of frequency:

- No mass casualty plan
- Operating room registry incomplete
- Lack of fire plan and drills
- No pathology index
- No x-ray index
- Fire hazard present
- No medical record index
- Inadequate medical library
- Lack of nurses' meetings and minutes
- No written staff applications.

Your questions will be welcomed. Send them to Mr. Steinle at HOSPITAL TOPICS, 30 W. Washington St., Chicago 2, Ill.

*See HOSPITAL TOPICS, January, February, March, April, 1957.

Ready Reference of Hospital Facts

For Planning and Operation

Part XVI

By Louis Block, Dr., P.H.

Tuberculosis Hospitals in the United States

● From 1946 to 1954 the activities of the tuberculosis hospitals in the United States have shown a decreasing tendency. This is especially true when one notes the following changes that have occurred in the number of facilities available, their utilization, finances and personnel. They now account for 5.3 percent of all hospitals; 4.7 percent of all beds; 4.5 percent of the average days of care provided; 0.4 percent of all admissions, and 4.0 percent of all expenses.

Facilities:

1. The number of hospitals has decreased by 44 (from 412 to 368)—a decrease of 10.7 percent.

2. The number of beds has decreased by 1,309 (from 74,867 to 73,558)—a decrease of 1.7 percent.

Utilization:

1. The average daily census has increased by 5,994 (from 54,696 to 60,690)—an increase of 11.0 percent.

2. The percentage of occupancy has increased from 73.1 percent to 82.5 percent.

3. The number of admissions has increased by 4,501 (from 84,734 to 89,235)—an increase of 5.3 percent.

Finances:

1. Total assets have increased $161,829,000 (from $32[illegible] 416,000 to $484,245,000)—an increase of 50.2 percent.

2. Total expenses have increased $115,220,000 (fr[illegible] $91,273,000 to $206,493,000)—an increase of 126.2 perce[illegible]

3. Total expenses per patient day have increased $4.[illegible] (from $4.57 to $9.32)—an increase of 103.9 percent.

4. Payroll expense has increased $80,393,000 (fr[illegible] $47,500,000 to $127,893,000)—an increase of 169.2 perce[illegible]

5. Payroll expense per patient day has increased $3.[illegible] (from $2.38 to $5.77)—an increase of 142.4 percent.

Personnel:

1. The number of full-time personnel has increased b[illegible] 13,345 (from 35,854 to 49,199)—an increase of 37.2 perce[illegible]

2. The number of full-time personnel per 100 patient[illegible] has increased by 15 (from 66 to 81)—an increase of 22.[illegible] percent.

The following presents some pertinent facts concerning the average nonprofit tuberculosis hospital in the United States.

The Average Nonprofit Tuberculosis Hospital in the United States*

Facilities:

1. Number of beds	107
2. Number of major operating rooms	1
3. Number of minor operating rooms	1

Utilization:

1. Number of annual adult admissions	159
2. Average daily adult census	84
3. Percentage occupancy	77.8
4. Average length of adult stay in days	192.0

Financial:

1. Total assets	$821,616
2. Plant assets	$512,959
3. Percent plant assets of total assets	62.4
4. Total annual expenses	$282,808
5. Total expenses per patient day	$9.27
6. Annual payroll	$139,151
7. Payroll per patient day	$4.56
8. Percent payroll of total expenses	49.2
9. Percent hospitals requiring funds for replacement	72.4
10. Number of $ per hospital required for replacement	$271,467

Services:

1. Percent of hospitals offering:	
a. Blood bank	7.6
b. Cancer clinic	1.5
c. Central supply room	37.9
d. Children's education program	18.2
e. Clinical laboratory	72.7
f. Dental department	54.5
g. Electrocardiograph	47.0
h. Electroencephalograph	0.0
i. Hospital auxiliary	22.7
j. Library, medical	51.5
k. Library, patient	84.8
l. Medical record department	72.7
m. Mental hygiene clinic	1.5
n. Metabolism apparatus	39.4
o. Occupational therapy department	50.0
p. Outpatient department	54.5
q. Pharmacy	48.5
r. Physical therapy department	18.2
s. Postoperative recovery room	16.7
t. Premature nursery	0.
u. Radioactive isotopes	1.5
v. Rehabilitation department	27.3
w. Social service department	43.9
x. X-ray diagnosis	87.9

*Based on information in American Hospital Association's Administrators Guide Issues (1951-1955).

y. X-ray, routine chest, on admission	78.8
z. X-ray therapy service	6.1
aa. Organized training programs for auxiliary nursing personnel	2.3

Personnel:

1. Number of full-time personnel	72
2. Number of full-time personnel per 100 patients	86
3. **Nursing personnel:**	
a. Total graduate nursing personnel	9
(1) Administrative graduate nursing personnel	1
(2) Full-time instructors	0
(3) Supervisors and assistants	2
(4) Head nurses and assistants	2
(5) General duty nurses, full-time	3
(6) General duty nurses, part-time	1
(7) Nurses not classified	0
b. Private-duty nurses	1
c. Practical nurses	10
d. Attendants	5
e. Nurses' aides	9
f. Ward maids	4
g. Orderlies	4
4. **Medical technologists:**	
a. Registered, full-time	0
b. Registered, part-time	0
c. Other full-time	1
d. Other part-time	0
5. **X-ray technicians:**	
a. Registered, full-time	0
b. Registered, part-time	0
c. Other full-time	1
d. Other part-time	0
6. **Occupational therapists:**	
a. Registered, full-time	1
b. Registered, part-time	0
c. Other full-time	1
d. Other part-time	0
7. **Physical therapists:**	
a. Registered, full-time	0
b. Registered, part-time	1
c. Other full-time	0
d. Other part-time	0
8. **Dietitians:**	
a. Full-time	2
b. Part-time	0
9. **Medical social workers:**	
a. Full-time	1
b. Part-time	0
10. **Pharmacists:**	
a. Full-time	0
b. Part-time	1
11. **Medical record librarians:**	
a. Registered, full-time	0
b. Registered, part-time	0
c. Other full-time	1
d. Other part-time	0
12. **Other medical record personnel:**	
a. Full-time	1
b. Part-time	0

DEPARTMENTAL

Governing board:

1. Number of members	13

Medical staff:

1. Percent hospitals with chief of staff	95.0
2. Percent hospitals with chiefs of services	51.7
3. Percent hospitals with written set of staff regulations	51.7
4. Percent hospitals with regularly scheduled meetings of staff	73.3
5. Percent hospitals with standing committees of the staff	30.0
6. Percent hospitals with executive committee of staff	29.9
7. Percent hospitals with medical record committee of staff	11.7
8. Percent hospitals with credentials committee of staff	10.4
9. Percent hospitals with tissue committee of staff	3.9
10. Percent hospitals with education committee of staff	2.6
11. Percent hospitals with pharmacy committee of staff	3.9
12. Percent hospitals with dietary committee of staff	2.6
13. Percent hospitals with nursing committee of staff	11.7
14. Percent hospitals with other committees of staff	2.6
15. Number of staff physician appointments	20
16. Number of active staff	9
17. Number of active staff per 100 beds	7
18. Number of associate staff	1
19. Number of associate staff per 100 beds	1

(Continued on next page)

FLEXIBLE RETIREMENT

Evolving Policies and Programs for Industry and Labor

Edited by Geneva Mathiasen

Hospital administration will find the studies contained in this book important since clues are provided for the successful continued employment programs for older workers.

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23.	Number of consultant staff per 100 beds	7
24.	Number of honorary staff	1
25.	Number of honorary staff per 100 beds	1
26.	Number of other staff appointments	0
27.	Number of other staff appointments per 100 beds	0
28.	Percent hospitals having psychiatrist on staff	46.9
29.	Percent hospitals reporting surgical restrictions on staff	73.3
30.	Percent hospitals permitting non-staff members to practice in hospital	32.1
31.	Percent hospitals providing examining rooms for ambulatory patients of medical staff	26.0
32.	Percent hospitals having private physicians' offices in hospital or on hospital grounds	15.2
33.	Percent hospitals having x-ray facilities available to private ambulatory patients of staff	43.9
34.	Percent hospitals having laboratory facilities available to private ambulatory patients of staff	44.0
35.	Percent hospitals accredited by the Joint Commission on Accreditation of Hospitals	38.4

Administrator:

1.	Percent hospitals in which chief administrative officer is a physician	41.9
2.	Percent hospitals in which chief administrative officer is a graduate nurse	2
3.	Percent hospitals in which chief administrative officer is other than a physician or nurse	3
4.	Percent hospitals in which chief administrative officer is a graduate of college course in hospital administration	1
5.	Percent hospitals in which chief administrative officer is a male	6
6.	Percent hospitals in which chief administrative officer is a female	3
7.	Percent hospitals in which one or more persons perform full-time as assistant administrator	4
8.	Percent hospitals having administrative staff member on duty at night	4
9.	Percent hospitals delegating administrative responsibility to night supervising nurse	4

Laboratory:

1.	Percent hospitals having all tissue removed at surgery routinely examined by a pathologist	8
2.	Percent hospitals having urinalysis on all admissions	8
3.	Percent hospitals having blood count on all admissions	7
4.	Percent hospitals having serological examinations for syphilis on all adult admissions	7
5.	Percent hospitals having electrocardiographs on all admissions over 45 years of age	2
6.	Percent hospitals having Rh grouping on all pregnancy cases	1
7.	Percent hospitals having preoperative blood grouping on all surgical cases	4
8.	Percent hospitals having preoperative coagulation on all tonsillectomies	5
9.	Percent hospitals having postoperative urinalysis on all surgical cases	2
10.	Percent hospitals having no tests without doctors' orders	6

Pharmacy:

1.	Percent hospitals operating pharmacies	3

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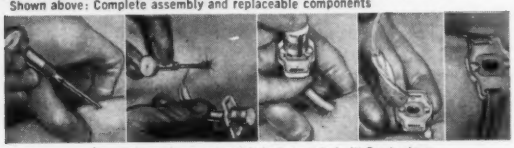

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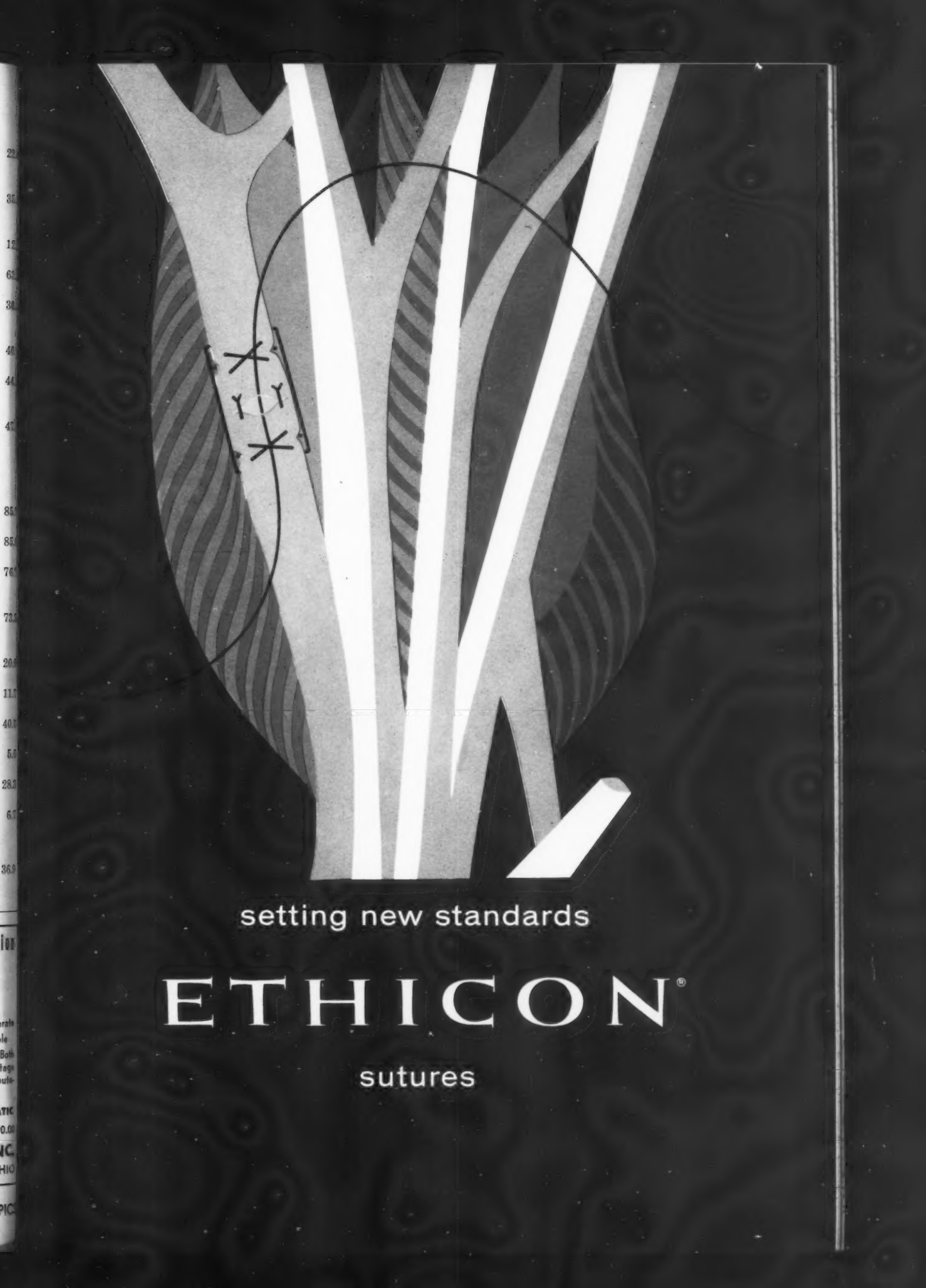
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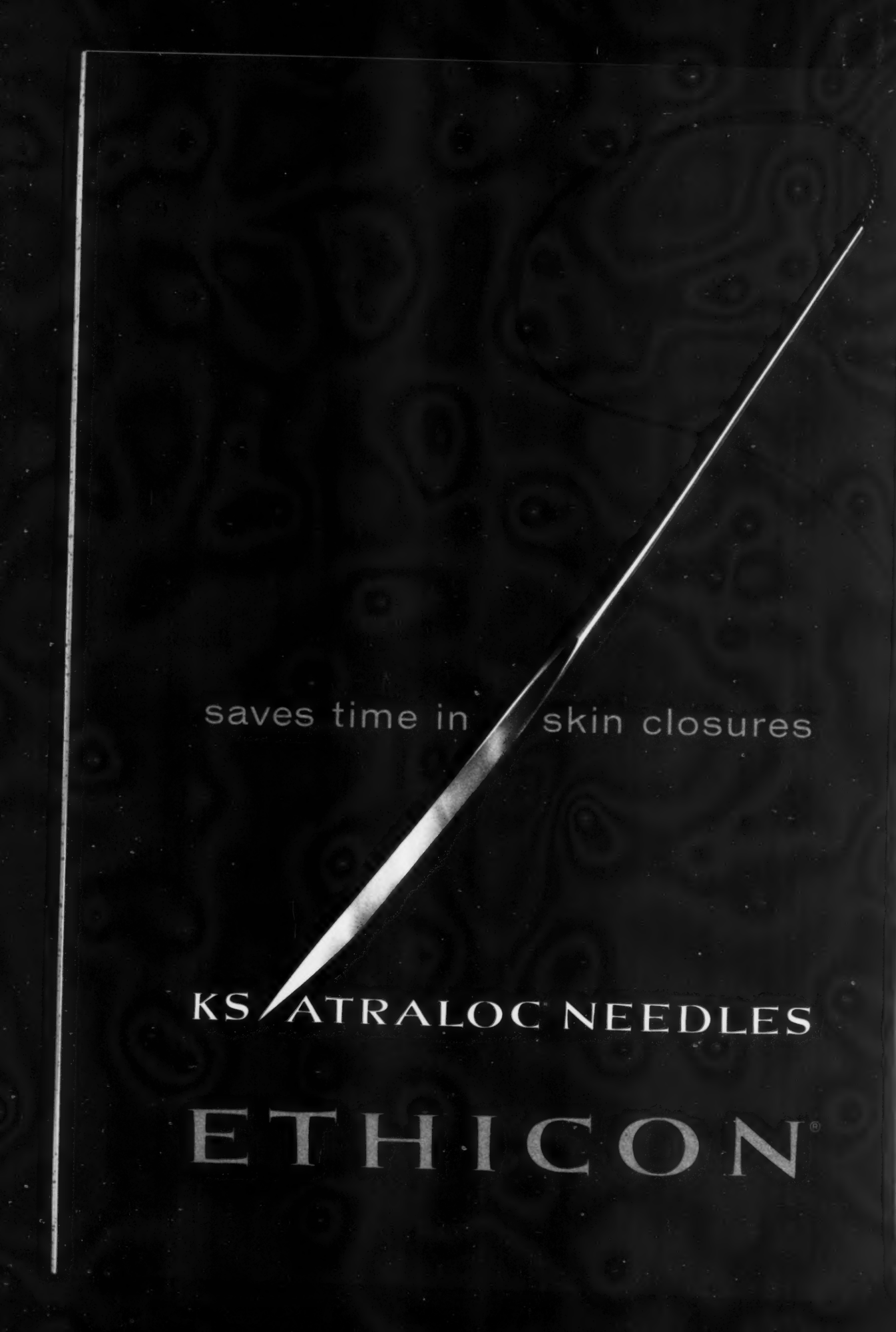

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2. Of those hospitals operating pharmacies, percent having full-time licensed pharmacist	25.0
3. Of those hospitals operating pharmacies, average number of full-time pharmacists	1
4. Of those hospitals operating pharmacies, percent manufacturing parenteral solutions	4.2
5. Percent of hospitals having formulary	46.2

Outpatient Department:

1. Percent hospitals having one or more outpatient clinics	40.4
2. Number of annual clinic visits	2,490
3. Number of annual private outpatient visits	1,527
4. Number of annual emergency visits	2,524

Medical Records:

1. Percent hospitals microfilming medical records	9.5
2. Number of annual deaths	13
3. Number of annual autopsies	4
4. Percent autopsies of deaths	27.8
5. Number of annual deaths released to legal authorities	2
6. Percent hospitals using Standard Nomenclature of Diseases and Operations	83.0

Admitting:

1. Percent hospitals using typewriter system for duplicating admitting records	65.0
2. Percent hospitals using mimeograph system for duplicating admitting records	0.0
3. Percent hospitals using liquid and gelatin system for duplicating admitting records	0.0
4. Percent hospitals using plate imprint system for duplicating admitting records	0.0
5. Percent hospitals using hand entry system for duplicating admitting records	15.0
6. Percent hospitals using other systems or combinations of above for duplicating admitting records	20.0
7. Percent hospitals routinely treating the following types of patients:	
a. Alcoholics	4.4
b. Cancer	7.4
c. Cardiac	13.2
d. Dermatologic	2.9
e. Drug addiction	1.5
f. Epileptic	0
g. Gynecologic	1.5
h. Isolation (contagion)	7.4
i. Leprosy	0
j. Medical	13.2
k. Mentally deficient	0
l. Neurologic	4.4
m. Obstetric	0
n. Ophthalmic	1.5
o. Orthopedic	4.4
p. Otorhinolaryngologic	1.5
q. Poliomyelitis	0
r. Psychiatric	1.5
s. Surgical	8.8
t. Tuberculosis	100.0
u. Urologic	2.9
v. Venereal disease	2.9
w. Acutely ill	59.7
x. Chronically ill	83.9
y. Students exclusively	0
z. Convalescent and rest	30.6
aa. Geriatric	6.5
bb. Industrial	6.5
cc. Pediatric	12.9
dd. Prisoners exclusively	0

Accounting:

1. Percent hospitals with ending date of fiscal year in—	
a. January	0
b. February	0
c. March	7.9
d. April	0
e. May	6.3
f. June	20.6
g. July	0
h. August	3.2
i. September	4.8
j. October	6.4
k. November	1.6
l. December	49.2
2. Percent hospitals which calculate depreciation	60.0
3. Percent hospitals which fund depreciation	23.3
4. Percent hospitals operating under formal budgets	69.0
5. Percent hospitals using AHA chart of accounts	42.1

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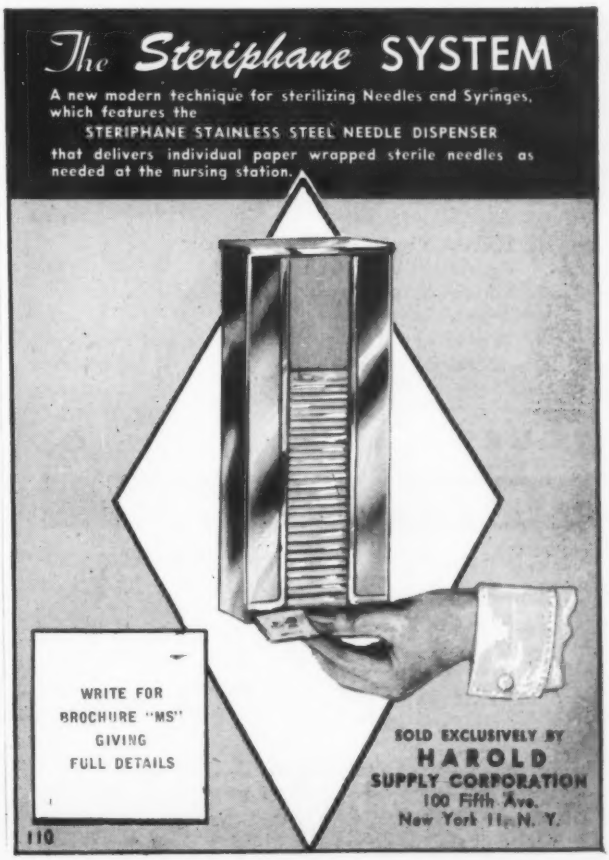
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Purchasing:

1. Percent hospitals with central purchasing department — 71.4
2. Percent hospitals with central purchasing departments with full-time purchasing agent — 17.8
3. Percent hospitals with central purchasing department with part-time purchasing agent — 64.4
4. Percent hospitals with central purchasing department with no reply as to purchasing agent — 17.8

Public Relations:

1. Percent hospitals using booklet for employees — 13.0
2. Percent hospitals using booklet for patients — 51.9
3. Percent hospitals using regularly published house organ — 20.8
4. Percent hospitals using printed manual report — 32.5
5. Percent hospitals using patient opinion poll — 14.5
6. Percent hospitals using personnel opinion poll — 7.3
7. Percent hospitals using medical staff opinion poll — 9.1
8. Percent hospitals using community opinion poll — 0
9. Percent hospitals using none of these (5-8) — 80.0

Dietary:

1. Percent hospitals with central food service layout — 79.7
2. Percent hospitals with decentralized food service layout — 22.3
3. Percent hospitals with selective menus for all patients — 33.9
4. Percent hospitals with selective menus for private patients only — 1.7
5. Percent hospitals not offering selective menus — 64.4
6. Percent hospitals with manual and centralized dishwashing — 13.8
7. Percent hospitals with manual and decentralized dishwashing — 7.7
8. Percent hospitals with mechanical and centralized dishwashing — 63.1
9. Percent hospitals with mechanical and decentralized dishwashing — 2

Laundry:

1. Percent hospitals operating own laundry and processing all soiled linen — 6
   a. Number of pounds per week — 7,09
   b. Number of pounds processed per patient day — 6
2. Percent hospitals operating own laundry and processing only a part of soiled linen — 5
   a. Number of pounds per week — 1,80
   b. Number of pounds per patient day — 2
3. Percent hospitals not operating own laundry — 2
   a. Number of pounds processed per week — 52
   b. Number of pounds processed per patient day — 1

Auxiliaries:

1. Percent hospitals having organized auxiliaries — 3

Safety:

1. Percent hospitals with organized safety committee — 2
2. Percent hospitals with written fire emergency and evacuation plans — 4
3. Percent hospitals with regularly scheduled fire drills — 3
4. Percent hospitals having own written plan for mobilization of employees and medical staff — 3
5. Percent hospitals whose written plan is integrated in master community plan — 2
6. Percent hospitals represented on a community disaster planning committee — 4

Religious:

1. Percent hospitals with a chapel — 48
2. Percent hospitals with a meditation room for prayer — 21
3. Percent hospitals with organized visiting clergy staff — 41
4. Percent hospitals having chaplains available — 10
5. Percent hospitals with full-time chaplains — 14
6. Percent hospitals with part-time chaplains — 0
7. Percent hospitals with chaplain on call only — 10

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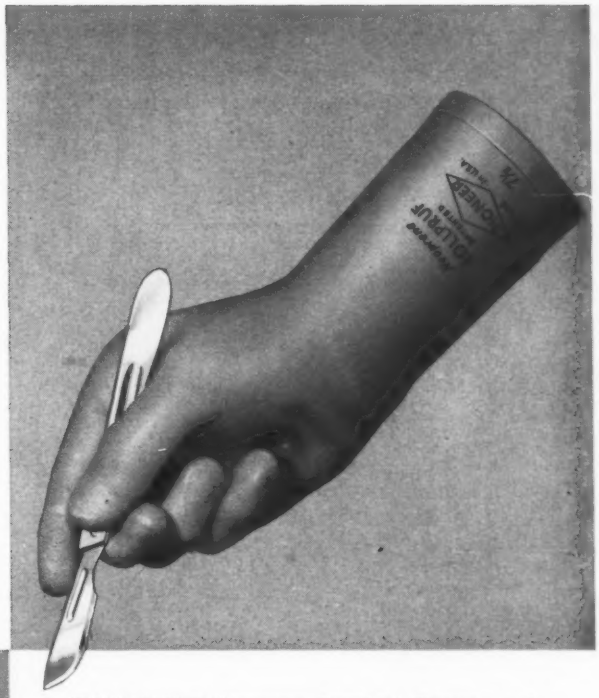

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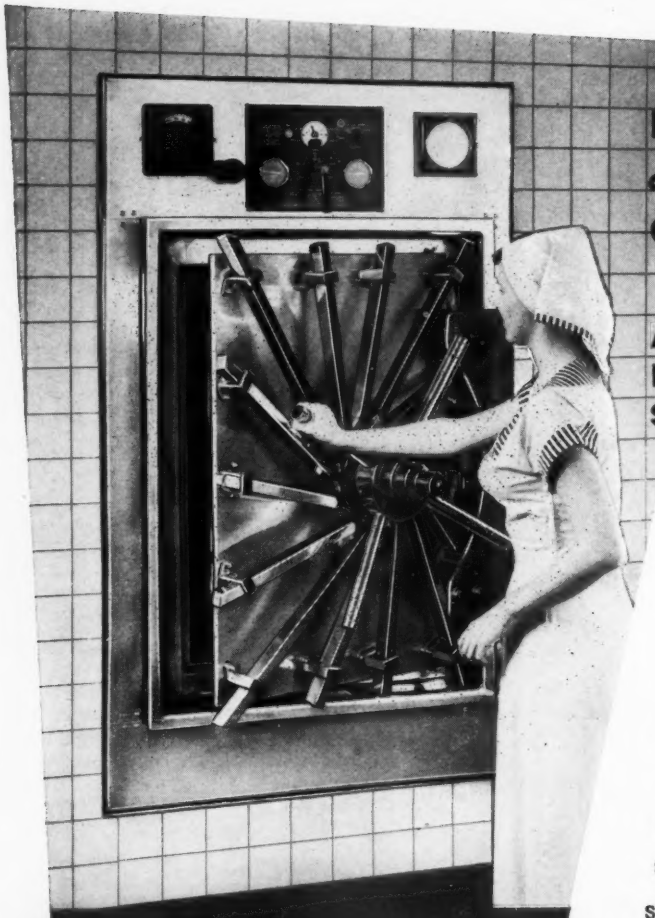

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REVIEW OF HOSPITAL

LAW SUITS

By Leo Parker, Attorney at Law

Subcontractors Liable

Must Prove Negligence

If a general contractor makes a contract with a hospital to safeguard the premises and protect persons from injuries while performing work, can an injured person recover damages from the hospital for injuries caused by a subcontractor?

According to a late higher-court decision, the answer is no, but the subcontractor is liable.

For illustration, in Nash Stone Setting Corp., 279 S. W. (2d) 518, it was shown that a hospital, a property owner, made a contract with a general contractor to perform certain work. The general contractor signed a contract with the property owner in which he agreed to keep the premises safe and safeguard pedestrians from injuries.

The contract called for the construction of an ornamental stone flower box in front of the building. For this purpose the general contractor dug a ditch extending from the front wall to the edge of the sidewalk. He laid a concrete foundation in the ditch, and a subcontractor built a stone facing from the ground up to the height of the flower box. To keep pedestrians passing on the sidewalk from inadvertently stumbling or walking into this hole, the general contractor put up barricades around it.

One day employees of the subcontractor worked in and about this excavation, getting the stone veneering on the flower box. It appears they were the only workmen at or near this excavation that afternoon. They did not complete the work but quit to go elsewhere to work. They left the site without replacing the barricade around the excavation and without doing anything to warn the public of this danger. That night a pedestrian fell into the open excavation and sustained severe injuries. He sued for damages.

During the trial, it was argued that the general contractor was bound by his contract with the property owner to maintain safeguards to prevent accidents and that the subcontractor was entitled to assume that the general contractor or the property owner would maintain barricades.

Although the lower court held the subcontractor not liable, the higher court reversed the decision, saying:

"The contractual obligations control the rights between the parties themselves but do not touch the rights of other persons or the public. The duty of every man to use due care not to harm his neighbor is imposed by law independently of contract. Our conclusion is that . . . . this defendant (subcontractor) owed a duty to exercise reasonable care not to endanger persons using the sidewalk, by leaving this excavation uncovered, unguarded, and unlighted; and that defendant (subcontractor) breached this duty and was guilty of negligence causing the damages sued for."

VISITOR MUST PROVE NEGLIGENCE

An official of a Cincinnati hospital asked: "What is the legal duty of hospital employes who park automobiles for visitors and physicians? What I really want to know is whether a hospital is liable in any way for injuries sustained by a visitor who slipped on a greasy spot after getting out of his car which he had driven into the hospital's parking lot."

Recently a higher court rendered an important decision, holding that, to recover damages for an injury, a visitor who drives his automobile into a hospital parking lot for any purpose, must conclusively prove that the hospital employees were negligent. In other words, the visitor's testimony alone will not result in the hospital's being liable.

For illustration, in Anaple v. Standard, 124 N. E. (2d) 128, it was shown that a visitor named Anaple slipped on some oil and suffered severe injuries. Anaple sued for heavy damages. During the trial, he proved that the grease on which he slipped was a "heavy grease" which had been used for lubricating shacklebolts, joints, etc. The lower court held Anaple entitled to heavy damages.

However, the Supreme Court reversed this verdict and, in holding Anaple not entitled to damages, said that there was no evidence as to how much grease was in a mere five-inch spot except the testimony of Anaple, who slipped on it. In other words, this higher court held that Anaple's testimony did not prove conclusively that his injuries resulted from negligence. The court said:

"Whether the duty of ordinary care requires such proprietor to prevent, remove, or warn against a particular hazard will necessarily depend on factors such as the potential hazard involved, the opportunity which such person apparently would or would not have to avoid that potential hazard by the exercise of ordinary care, and the practicability of preventing, removing, or warning against such hazard."

For comparison, see Plotts v. Albert, 260 Pac. (2d) 621. Testimony in this case showed that a woman 91 years of age was walking on grass when she stumbled over a small stake about three inches wide, and less than an inch thick, embedded in the ground with the top protruding an inch or more above the surface. The stake was somewhat obscured from view by grass. She sued for heavy damages. The higher court said:

"One is said to assume a risk when she freely, voluntarily and knowingly manifests her assent to a dangerous condition, and voluntarily exposes herself to that danger, or when she knows, or in the exercise of ordinary care would know, that a danger exists in the condition of the property."

MUST FOLLOW STANDARD PROCEDURE

According to a late higher court decision, a hospital is liable in damages to a patient for an infection caused by

(Continued on page 104)

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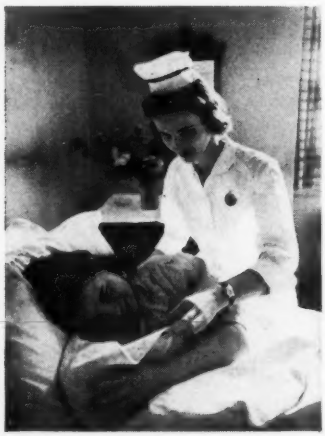
for patients troubled by HEMORRHOIDS



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HOSPITAL

Trends

BY LOUIS BLOCK, Dr. P H.

Solving the Rate Problem

A major consideration in the problem of hospital finance is how to obtain an equitable distribution among the sources of income needed to cover the costs of hospital care. This involves the problem of hospital rates or charges.

Hospitals have been accused of having a rate structure that has grown like "Topsy"—with no apparent reason and with no relationship to good business procedure. This is not necessarily true. Despite the fact that hospitals have been unbusinesslike in their methods of establishing rates, their past experiences have been the deciding factor.

From a business point of view, hospitals have been deficient in their manner of determining rates because these rates have not been based on the costs of services rendered. There are many factors that relate to the question of hospital rates. Some are tangible; others are not.

The tradition of hospital growth in this country is that of a nonprofit social organization with deficits underwritten by gifts and endowments. This tradition has created a rate structure that in ordinary business would lead to insolvency. With decreasing endowments, hospitals were placed in a position of having to alter their rate structures in order to keep their doors open. They had to find ways of getting more and more support from the people who were using their facilities.

This meant a more businesslike approach to the question of hospital financing. But tradition is hard to change. The idea of charity or free service has never been abandoned by the hospitals in this country. Its scope, however, has been limited and modified.

With the use of the hospital by more and more people and with its services being made available to all economic levels, approximately nine-tenths of general hospital income today comes directly from or in behalf of patients. This raises the question of the equity of charges to those using the services.

In studies made, hospitals have been found lacking in knowledge as to operating costs upon which to base a logical approach to the establishment of a rate structure. Although much progress has been made, it is still true that hospital charges bear little relation to the cost of services provided.

These studies have further emphasized that:

(1) Private and semiprivate patients are paying rates above the cost of services they are getting.

(2) Agencies responsible for certain population groups are not paying the full cost of services to these patients.

(3) Ward patients pay less than the cost of their services.

(4) Definite inequities exist in rates which patients pay for routine and special services.

These statements are unquestionably true. Hospitals have increased their rates much more rapidly for special services than for routine services. In fact, charges for special services are way out of line with their costs.

The reverse is true of routine services. For several reasons, hospitals have been reluctant to raise these charges enough to meet the cost. This routine service rate is usually the rate quoted for service when a patient makes inquiry. It is uniform within the accommodation class. It is too often compared with hotel service, and comparisons are unjust and inaccurate. However, it is a service that the patient understands.

Special services are newer in development and still carry an aura of mystery to the patient. They are like the doctor's prescription—necessary, but understandable only to a comparative few. Rate increases in the special service area have, therefore, brought less objections.

Despite these facts, it is generally recognized that until hospital administration incorporates a sound, uniform accounting and statistical system whereby accurate costs can be determined, the establishment of rates on the basis of costs is impossible.

It is of interest to those responsible for providing hospital care, and those receiving such care, to know something of what has been happening to the rate structure in hospitals.

Basically, there are three kinds of rates in general use in hospitals—inclusive rates, partially inclusive rates, and separate rates for each unit of service.

THE INCLUSIVE RATE

The inclusive rate for hospital service is a single daily rate charged for all services furnished to patients on a consistent and uniform basis, without regard to actual service provided. The only basic variations that

(Continued on next page)

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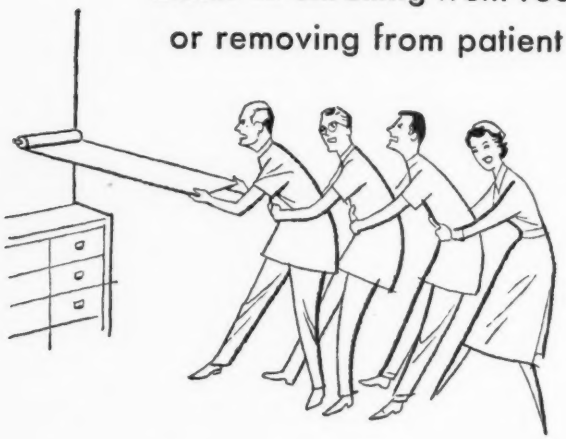

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occur arise from differences in length of stay and type of accommodation. The application of this type of rate structure is based on a share-the-hazard principle similar to that used by insurance companies, public utilities, and even group hospitalization plans.

This type of rate structure has the following advantages to the patient, the physician, and the hospital:

(1) A complete understanding among patient, physician, and hospital on charges for care.

(2) The removal of friction over a long list of annoying minor charges which are frequently difficult to interpret.

(3) A tendency to encourage a thorough diagnosis since patients are not denied necessary services through their own or their physician's desire to keep the bill down.

(4) Saving of valuable time of hospital personnel by elimination of work accompanying charge memoranda and bookkeeping.

(5) Facilitation of adjustment of rates to costs.

(6) Reduction and even elimination of complaints regarding "extras."

The disadvantages associated with this type of rate structure are:

(1) Increased use, or abuse, of special services.

(2) Impossibility of measuring financial effect of work performed by the various special service departments.

(3) Increased cost of special service departments because of increased volume of work.

(4) Interference with contact arrangements with radiologists and pathologists.

(5) Objections of patients to paying for "someone else's bill."

THE PARTIALLY INCLUSIVE RATE

This type of rate structure follows a general basic pattern but has pre-established charge differentials between major and minor surgery, obstetrical, medical, and other patient service types, such as short-stay and long-stay care.

It also includes a further variation which could be considered as a limited type of inclusive rate. This is a special predetermined rate for only certain types of care such as maternity, tonsillectomy and adenoidectomy, and routine laboratory service.

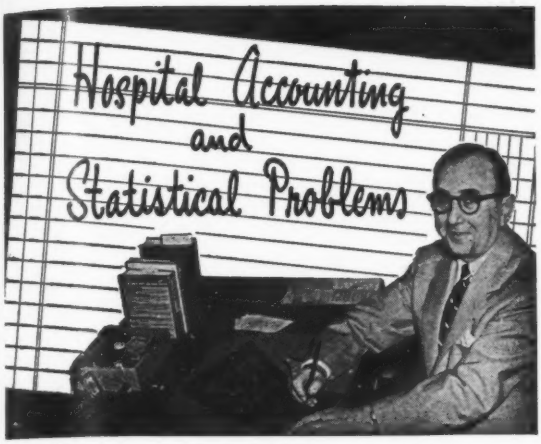
SEPARATE RATE FOR EACH UNIT OF SERVICE

This rate structure is perhaps the most generally used. It provides for separate charges for room, board, and routine services based upon the type of accommodations furnished. Under this plan separate charges are also established for each service rendered by each special service department.

ED. NOTE: For Dr. Block's comprehensive analysis of this and many other subjects, see his book, *Hospital Trends* (Chicago: HOSPITAL TOPICS, 1956).

NEXT MONTH

Survey of Current Rate Practices



By David H. Tarlow, C.P.A.

Senior Partner, D. H. Tarlow & Co.

Hospital Accountants and Auditors, New York City

Q. In the April issue of HOSPITAL TOPICS you stated that a retired individual receiving Social Security benefits may earn up to $1,200 per annum without impairing his benefit status. Is not the age of the individual a determining factor?

A. The age of the recipient *is* a determining factor. If he is over 72, he may earn any sum without losing his Social Security benefit status. However, the question as asked cited the $1,200 limitation, and this sum does not affect payments to any retired individual.

* * * * *

Q. Is there any generally accepted policy of allowing discounts to an employee or medical staff member for hospitalization? If so, can you give us some idea of the percentages allowed for this purpose?

A. This is an administrative policy which varies in different institutions. We would suggest that you write to the American Hospital Association for any data they may have on this subject.

* * * * *

Q. A problem which is fast assuming major proportions in our hospital is the repeated request for duplicate bills or statements, long after the patient has been discharged from the hospital. To comply with all such requests requires an average of twenty hours each week in our hospital. To refuse them would tear down all efforts we have expended in creating that intangible called good will.

We are particularly conscious of this pressure at the end of the year, during tax time, when we have so many other duties in the accounting department, such as the preparation of the W-2 payroll reports and usual book-closing problems. Can you tell us how other hospitals are handling this problem, since I am sure we are not the only ones facing this condition.

A. There are two methods in use, to our knowledge, which have materially assisted in reducing this problem. First, bills are prepared in duplicate during the patient's stay at the hospital by means of a carbonized form. Only one bill is given to the patient, or the party responsible for the bill, at the time of the patient's discharge, while the other is retained with the ledger account card. This other invoice is kept for one year and then destroyed if not requested.

The second method calls for the purchase of a small offset duplicating machine which is used both for duplicating invoices and making transcripts of patient's charts. Demands for the latter have also been on the increase because of the many requests from insurance companies as well as court demands. We recommend the second method and have found it most practical.

Q. We read Mr. Spencer's article on "Funding Depreciation" in the April issue of HOSPITAL TOPICS with great interest. However, while our board of trustees is agreed that this method is most practical, we are supported by a Community Chest which does not accept depreciation as an element of expense but insists on replacements only being included in the budget and operating statements as an item of expense. We realize that to show both replacements and depreciation as operating expenses would not be proper from an accounting standpoint, yet we feel that some change should be effected in our presentation of costs to third-party paying agencies. This problem becomes more difficult when officials of such agencies insist on a copy of our formal report which is prepared by the Chest auditors. Naturally, these reports show replacements and not depreciation as an operating expense. Do you have any suggestions as to how we can meet this problem? Further, what rates or basis would you recommend for establishing a funded depreciation account, and would you please demonstrate the entries required for accounting purposes.

A. Third-party paying agencies, in general, have been accepting depreciation as an element of a hospital's operating expense. You can, therefore, include an amended statement with your audit report to show the resultant cost figures for reimbursement. We recognize that only a portion of your cases are covered by third-party paying agencies. Hence, unless your charges for services rendered are more nearly geared to cost than they are now, the Community Chest must ultimately grant your hospital greater sums to meet budgetary requirements than they would if your hospital could increase its earnings. This condition should be brought to their attention if you have not already done so.

With respect to rates and method for establishing the depreciation reserve, we suggest an annual rate based on 2 percent of building value and 10 percent of equipment value. We further suggest that the entries for reflecting these accruals be recorded at the close of each month in the general journal in the following manner:

Depreciation of Buildings .....
Depreciation of Equipment .....
Reserve for Depreciation .....
To record depreciation for the month of.....
at the rate of 2 percent for buildings and 10
percent for equipment per annum.

Subsequent to this entry, a check for the total amount should be withdrawn from the operating account and deposited in a replacement or reserve account. The entry for this transfer will be recorded in your cash disbursements journal the same as any other check issued. When replacements, purchases of new equipment, or major alterations or additions are authorized, such items should be paid for with funds from this account and the resultant purchase capitalized. In this manner, depreciation will be shown as an operating expense and, as such, included in cost determination of units of service rendered, while replacements or additions will be capitalized. We would also suggest that you install an equipment ledger as a detailed subsidiary to the equipment control account in the general ledger for administrative guidance.

Personally Speaking

James L. Ambrose — has been appointed administrator, Doctors Memorial Hospital, Perry, Fla.

Bertha M. Anderson, R.N. — has retired from the Visiting Nurse Association of Sangamon County (Ill.), after 50 years as a nurse, 26 of them with the association.

Thomas L. Askew — has been appointed administrator, King's Daughters Hospital, Yazoo City, Miss., succeeding **Winston Whitfield,** who has become administrator, Colbert County Hospital, Sheffield, Ala.

W. Thomas Barnes—has become controller and assistant treasurer, Johns Hopkins Hospital, Baltimore, Md., succeeding **Harry O. Humbert,** who has accepted a similar position at Roosevelt Hospital, New York City.

Edward S. Baron—has become administrator, New Milford (Conn.) Hospital. He was formerly controller, Charlotte Hungerford Hospital, Torrington, Conn.

Evelyn Belknap, R.N. — has become director of nurses, Mississippi Baptist Hospital, Jackson, succeeding **Barbara Odom,** who has resigned. Miss Belknap was formerly director of nurses, Vicksburg (Miss.) Hospital.

Isola Benedettie, R.N. — has become director of nurses, North Broward General Hospital, Ft. Lauderdale, Fla., succeeding **Katherine Torrance, R.N.,** who has become director of nurses, South Florida State Hospital.

Neva C. Bridgman, R.N.—supervisor of nursing, Wabash Employees' Hospital, Decatur, Ill., has retired after 32 years' service. **Dorothy Dodsworth, R.N.,** assistant supervisor, will succeed her.

S. K. Bronstein—has become associate director, Jackson Memorial Hospital, Miami, Fla., where he will also continue as clinic administrator.

Kenneth W. Chapman, M.D.—has been appointed associate director, Clinical Center, PHS National Institutes of Health, Bethesda, Md.

Jesse Cofty—has become administrator, Cookeville (Tenn.) General Hospital.

Arkell B. Cook—has resigned as administrator, Evanston (Ill.) Hospital, to become administrator, Butterworth Hospital, Grand Rapids, Mich.

Robert C. Couch — has been named administrator, Cherokee County Hospital, Centre, Ala. He was formerly assistant administrator, Hamilton Memorial Hospital, Dalton, Ala.

W. P. Crandall, M.D. — has resigned as superintendent, Oklahoma State Veterans Hospital, Sulpher, Okla.

John M. Danielson—has been named administrator, Evanston (Ill.) Hospital. He was formerly administrator, North Shore Hospital, Manhasset, N. Y. He succeeds **Arkell B. Cook,** who has become executive director, Butterworth Hospital, Grand Rapids, Mich.

Mrs. Selma P. Deyo—has become acting business manager, Huntington (W. Va.) State Hospital, succeeding **Homer E. Peyton,** who has resigned.

James Duff—has been appointed business manager, Naples (Fla.) Community Hospital.

Mrs. Clara A. Ely—has been named physical therapist, North Broward General Hospital, Ft. Lauderdale, Fla.

Wayne Foster—has been elected president, Ohio Hospital Association. He is administrator, Holzer Hospital and Clinic, Gallipolis, O.

John F. Gallagher — has been appointed administrative assistant, Mercy Hospital, Baltimore, Md. He will also continue as purchasing agent.

Mrs. Helen Gould, R.N.—has resigned as superintendent, Grundy Co. Memorial Hospital, Grundy Center, Ia.

Dudley Hall—has been named assistant, Harris Hospital, Ft. Worth, Tex., a newly-created post. He was formerly administrative assistant.

Oren B. Haynes — has become chief engineer, Southwest Florida Tuberculosis Hospital, Tampa.

W. Vaughn Herrin—has become administrator, Methodist Hospital of Central Illinois, Peoria, succeeding the late **W. T. Smith, D.D.** Mr. Herrin was formerly assistant executive director.

J. D. Howell—has been named office manager, Deaconess Hospital, Spokane, Wash., succeeding **Frank Slemmer,** who has resigned to accept another position.

Harry O. Humbert—has become controller-assistant treasurer, Roosevelt Hospital, New York City.

Harvey S. Jacobs—has been appointed field representative, Children's Mercy Hospital, Kansas City, Mo., succeeding the late **Russell W. Preston.**

Muriel Kragh—has been appointed director of nurses, Wuesthoff Memorial Hospital, Rockledge, Fla.

Arthur E. Landon—has become administrator, Asbury Hospital, Salina, Kans., succeeding **Jack F. Hensley,** who has resigned.

Ted O. Lloyd—has become executive director, Missouri Hospital Association.

Barbara J. Lee—has been appointed assistant administrator, University Hospital, Little Rock, Ark. She was formerly administrative assistant, Mountainside Hospital, Montclair, N.J.

M. Frank Massey—has become administrator, Piedmont Memorial Hospital, Greensboro, N.C. He was formerly personnel director, Moses H. Cone Memorial Hospital, Greensboro, N.C. In the May issue he was incorrectly identified as administrator, Cone Memorial Hospital.

Mrs. Janet Mastin — has been appointed director, dietary department, University Hospital and Hillman Clinic, Birmingham, Ala.

Wilbur Mauzy—has become administrator, new Howard County Hospital, Kokomo, Ind. He was formerly administrator, Memorial Hospital of Floyd County, New Albany, Ind.

E. Duncan Millican—president, Quebec Hospital Service Association, Montreal, Can., has been named to the Blue Cross Commission, succeeding **F. D. MacCharles,** executive director, Manitoba Hospital Service Association, Winnipeg, who has resigned.

Lloyd Mader—has been named public relations consultant, St. Anthony's Hospital, St. Petersburg, Fla.

Ada I. Mitchell, R.N.—has become administrator, Williams County General Hospital, Montpelier, O., succeeding **Justin W. Greene,** who has resigned.

Margaret R. Mullen, R.N. — has resigned as director of nursing and principal, school of nursing, Western Pennsylvania Hospital, Pittsburgh.

Rosemary Neagle—has been appointed chief dietitian, Norwalk (Conn.) Hospital.

William B. Ober, M.D. — has been appointed director of pathology, Knickerbocker Hospital, New York City. He was formerly assistant pathologist, Hackensack (N.J.) Hospital.

Eugene J. O'Meara—has become administrator, Sharon (Pa.) General Hospital. He was formerly assistant superintendent, Altoona (Pa.) Hospital.

Blanche Ostlund, R.N.—has been appointed assistant chief, nursing education, VA Hospital, Whipple, Ariz. She formerly held a similar position, VA Hospital, San Francisco.

Bob Peery—has become administrative assistant, Mound Park Hospital, St. Petersburg, Fla., where he was formerly administrative resident.

Alfred Petschow — has become purchasing agent, St. Anthony's Hospital, St. Petersburg, Fla.

Frank L. Porter—has been named assistant administrator, Shore Memorial Hospital, Somers Point, N.J.

Boone Powell—administrator, Baylor Hospital, Dallas, Tex., has been named president-elect, Southwide Baptist Hospital Association.

Harriet Schacht, R.N.—has been appointed assistant chief, nursing service, VA Hospital, McKinney, Tex. She was formerly educational consultant, State Board of Nurse Examiners, Montgomery, Ala.

Richard E. Scully, D.D.—has become superintendent, Bethesda Home, Cincinnati, O. He was formerly general manager, Methodist Home for the Aged, College Hill, Cincinnati, O.

Barbara Schwenger—has become executive housekeeper, Danbury (Conn.) Hospital. She was formerly with Palo Alto (Calif.) Hospital.

Charles Shepherd — has been named administrator, Watkins Memorial Hospital, Quitman, Miss., succeeding **H. C. Watkins, M.D.**, who will return to full-time medical practice.

Sister Carmeline—formerly in charge, children's department, St. John's Crippled Children's School and Hospital, Springfield, Ill., has become superior, St. Francis Hospital, Litchfield, Ill., succeeding **Sister Leonissa.**

Sister Electa, D.C. — has succeeded **Sister Rosaria** as administrator, St. Vincent's Hospital for Women and Children, Philaldelphia.

Sister M. Alice—has become administrator, St. Francis Hospital, Holdenville, Okla., succeeding **Sister M. Virginia**, who has been transferred.

Leonard J. Smith—has been appointed accounting manager, Danbury (Conn.) Hospital.

Leslie R. Smith—has been appointed assistant director, Harbor General Hospital, Torrance, Calif. He was formerly senior administrative assistant, Rancho Los Amigos Hospital, Hondo, Calif.

Paul J. Spencer—has become director, Faulkner Hospital, Jamaica Plain, Boston, succeeding **Gerald F. Houser, M.D.**

Ralph N. Steele—has been named business manager, Weston (W. Va.) State Hospital, succeeding **Henry J. McKinley.**

H. S. Tait, M.D.—has become assistant director, mental hygiene clinic and treatment center, VA Hospital, Wheeling, W. Va. He was formerly superintendent, Weston (W. Va.) State Hospital.

Sherman Thompson—has been appointed administrator, Ontario (Cal.) Community Hospital.

John C. Van Metre—has become administrator, Opportunity Home and Hospital, Toledo, O. Formerly administrator, Northern Indiana Children's Hospital, South Bend, Ind., Mr. Van Metre succeeds **Samuel White, Jr.**, who has resigned.

Mr. and Mrs. Clarence Ward—have been appointed superintendent and matron, respectively, Winnebago, (Wis.) County Hospital. Mr. Ward was formerly administrative assistant, Winnebago (Wis.) State Hospital, where Mrs. Ward has been staff nurse.

Mrs. Alma Warden, R.N.—has been appointed superintendent of nurses, Cookeville (Tenn.) General Hospital.

Claude L. Weeks—has become administrator, Cherokee County Memorial Hospital, Gaffney, S.C. He was formerly administrator, Newberry (S.C.) County Memorial Hospital.

Emanuel Weisberger—has resigned as superintendent, Cedars of Lebanon Hospital, Los Angeles, effective July 1.

Preston Williams—has been appointed administrator, Robberson-Shirley Hospital, Wynnewood, Okla., succeeding **S. N. Barrett**, who has resigned.

(Continued on page 63)

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DIRECTOR OF NURSES: (a) East. Large hospital. Affiliated with university. To $10,000. (b) University Hospital, two new buildings will be completed soon. About 400 beds. To $7500. (c) Middle West. 125 bed hospital in college town. To $7200. (d) Superintendent. 50 bed hospital, near Boston. Capable of directing hospital in absence of administrator. $5000 minimum. (e) Director of Nursing Service. Degree not required. Summer resort city in middle west. 200 bed hospital. $6500. (f) Middle West. 175 bed hospital in city of 60,000. $7000-$7500 plus maintenance. (g) South. New 250 bed hospital; air conditioned in city of 75,000.

PHYSICAL THERAPISTS: (a) West. Supervise dept. of large hospital; 6 employees. $5400. (b) South. Chief. Organize new dept. Excellent opportunity. 300 bed hospital in city of 100,000. (c) Staff. California. 300 bed hospital; 8 in dept., which is very active. $4800. (d) Middle West. 100 bed hospital. Experience treating Cerebral Palsy. $5400 plus full maintenance.

DIETITIANS: (a) Traveling Field Dietitian. 6 eastern and southern states. Prefer A.D.A. with at least 3 years experience. $5400 plus expenses. (b) Chief. Middle West. 50 bed hospital. $5400. (c) Therapeutic. Middle West. 125 bed hospita' in college town. To $5400. (d) Consulting Dietitian. Middle West. Supervise 3 hospitals within radius of 60 miles. Good salary plus liberal traveling expenses. (e) Chief, Northwest. 100 bed hospital in town of 35,000. $6000.

NOTE: We can secure for you the position you want in the hospital field, in the locality you prefer. Write for an application—a postcard will do. All negotiations strictly confidential.

TRADE TOPICS . . .

Alfred C. Einstein, assistant sales manager, Shampaine Co., demonstrates Hampton obstetrical table to group of 55 graduating hospital administration students from St. Louis and Washington universities who attended the sixth annual tour and discussion seminar in hospital equipment, held at the Shampaine Co.

Promotions Announced at Ohio Chemical

William Lunger will become president, Ohio Chemical & Surgical Equipment Co., division of Air Reduction Co., in July, succeeding Robert Lenhard.

Mr. Lunger was formerly vice-president in charge of sales. Mr. Lenhard will be executive vice-president, Air Reduction Sales Co.

Charles A. Simpler has been promoted to general sales manager, and L. E. Guentz has been named to succeed Mr. Simpler as regional sales manager in Chicago.

Art Whittington (r.) is congratulatd by Ken Voit, southeastern division manager, Cutter Laboratories, for attaining first place in southeastern division sales for 1956. Mr. Whittington was awarded a wristwatch.

District Sales Managers Named At Bauer & Black

Thomas Brown, former hospital sales representative for Bauer & Black in Seattle, is now district sales manager for the central hospital district.

Alan Schlosser, former central hospital district manager, has become sales manager of a new hospital district, with headquarters in Philadelphia.

Eaton Laboratories Announces New Appointments

W. T. Rockhold, Ph.D., is new chief, pharmacology section, Melvin C. Eaton Research Laboratory.

Loudon Lee Campbell III has joined the advertising department of Eaton Laboratories. He was former editor of professional literature, Parke, Davis & Co.

Parke-Davis Honored for Distinguished Advertising

One of 26 awards for "distinguished advertising in the public interest" has been made by *The Saturday Review* to Parke, Davis & Co.

Parke-Davis has been sponsoring advertisements on the theme, "Prompt and proper medical care may well turn out to be one of the biggest bargains of your life."

Hospital Industries' Association award for best exhibit at New England Hospital Assembly went to American Sterilizer Co. Left to right are Reo J. Marcotte, M.D., director, Mt. Auburn Hospital, Cambridge, Mass.; James Dyett, president, HIA, and Randolph Hinch, district manager, American Sterilizer Co.

Abbott Announces Promotions, New Assignments

David M. Kennedy, president and member of the board of directors, Continental Illinois National Bank and Trust Co., Chicago, and Frederick J. Kirchmeyer, director of new products, Abbott Laboratories, have been elected to Abbott's board of directors.

Edward A. Ravenscroft was promoted from vice-president and comptroller to financial vice-president. James F. Stiles, Jr., formerly treas-

The Hausted Mfg. Co. is now occupying its new building in Medina, O., after a fire last September destroyed the old Hausted office and factory. The new office (above) and factory provide vastly enlarged area.

urer and chairman of the board, became chairman of the board and chairman of the finance committee. He was succeeded by Robert V. Jaros, who has been assistant treasurer.

Promotions and new assignments in Abbott's scientific divisions include: Dr. William B. Brownell to manager of analytical research and specifications; Herbert C. Duescher to manager, control laboratories, and William A. Lennox to assistant manager, control laboratories.

Dr. William L. Hartop, Jr., was promoted to assistant head, special projects department, and Dr. Herbert M. Gross was named assistant to director of new products.

Robert L. Jones has been named assistant to director of research. Assigned to serve with the director of research evaluation was Dr. Benjamin E. Greenwell.

X-Ray Film Hanger Repair Service Announced

Ostrander, x-ray specialties firm, 313 Lincoln Ave., Collingdale, Pa., has established an x-ray film hanger repair service. Orders for complete repairs and cleaning of hangers are accepted from all states.

Bryce L. Twilty (l.), president, Mid-West Hospital Association, presents award for outstanding exhibit to Elmer A. Holford, Johnson Service Company, Milwaukee, Wis.

Sterling Drug Plans Expansion Into Vaccine Production

The Sterling-Winthrop Research Institute is entering the field of biologicals, including vaccines, for the treatment of virus diseases.

James Hill Jr., chairman of the board, has announced that major increases are slated in the Institute's biological research facilities. Chemical and pharmaceutical research laboratories will also be expanded. A new product development building will be erected to work out chemical processes required for large scale manufacture of new pharmaceutical products.

New Appointments Named At Bristol Laboratories

George M. French and Walter Smith have been named to newly-created positions of regional managers, Bristol Laboratories, Inc.

Mr. French will supervise the Southeast and Southwest. Mr. Smith's territory is the Midwest and East.

Changes in the medical department are Robert L. Vought, M.D., from associate medical director to director of medical coordination, and Howard A. Albright, from associate medical director to director of clinical investigation.

Wyeth Laboratories Makes Executive Appointments

Russell A. Beeson, Wyeth Laboratories vice-president, has become administrative vice-president. Charles J. Kern moves up from assistant to the president to vice-president in charge of research and development.

(Continued on page 79)

NEW!...

Velvetex

color band surgical gloves

Now treated with BIO-SORB® *dusting powder**

This treatment gives you...

Improved lubrication for easier donning

Less wear and tear . . . tackiness eliminated

Less rapid degradation of tensile strength in autoclaving

*The powder that eliminates post-surgical adhesions caused by talcum powder.

Plus these features...

- **PERMANENTLY** color banded for quick mating
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When the FLEET ENEMA Disposable Unit replaces old-fashioned enema equipment, personnel are released for other duties.*

FLEET ENEMA Disposable Unit is *safe* to use . . . the anatomically correct rectal tube minimizes injury hazard. FLEET ENEMA is *easy* to use . . . plastic squeeze bottle permits the "infinite ease of the one hand squeeze." Each FLEET Disposable Unit contains an enema solution of Phospho-Soda (Fleet) . . . gentle, prompt and *more effective* than one or two pints of soap suds or tap water.(1)

* *"It is possible to give seven enemas with the Fleet Disposable Unit in the time required to administer one soapsuds enema."*

Standard vs Disposable Unit Enema: Rainier, W. G. and Lee, B., Hospitals, 31:50, January 1, 1957.

(1) Swinton, N.W., Surg. Clin. No. Am., 35:833, 1955

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makers of Phospho-Soda (Fleet)

In Canada: Produced by Charles E. Frosst & Co.

PERSONALLY SPEAKING

(Continued from page 59)

VA Appointments

John W. Bell, M.D.—has been appointed chief, surgical service, VA Hospital, Seattle, Wash., succeeding **J. Thomas Payne, M.D.**, who has retired to private practice.

Edward R. Bennett, M.D. — director, professional services, VA Hospital, Biloxi, Miss., has been reassigned as manager, VA Hospital, Pittsburgh, succeeding **Lee G. Sewall, M.D.**

Earl P. Brannon, M.D. — formerly manager, VA Hospital, Perry Point, Md., has been transferred to VA Hospital, Coatesville, Pa., as manager, succeeding **Henry Luidens**, who has resigned.

Thomas P. Crane, M.D. — formerly manager, VA Hospital, Dearborn, Mich., has become manager, VA Hospital, San Francisco, succeeding **James G. Donnelly, M.D.**, who has retired.

Chalmer Davee, M.D.—has been appointed manager, VA Hospital, Marion, Ill., succeeding **Edward A. Welch, M.D.**, who has retired. Dr. Davee was formerly director, professional services, VA Hospital, Hot Springs, S.D.

Lee G. Sewall, M.D.—has become manager, Perry Point, Md., succeeding **Earl P. Brannon, M.D.**

VA Nursing Appointments

Charlotte Collier, R.N. — has become assistant chief, nursing service and education, VA Hospital, Excelsior Springs, Mo. She was formerly an instructor, VA Hospital, Houston, Tex.

Charles Davis, R.N. — has become assistant chief, nursing service, VA Hospital, Danville, Ill. where he was formerly assistant chief, nursing education.

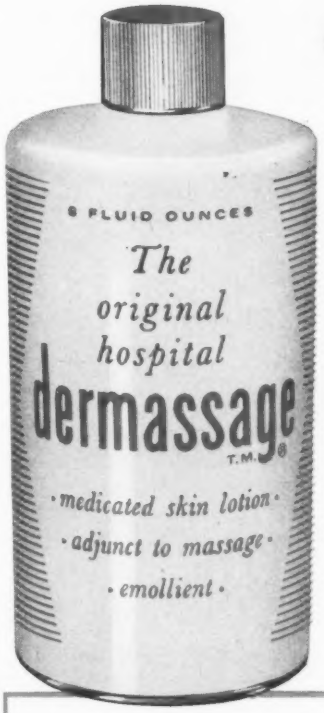
Grace Farley, R.N.—has become chief, nursing service, VA Hospital, Beckley, W. Va. She was formerly assistant chief, nursing service, Syracuse, N.Y.

Minnie Hartsfield, R.N. — is now assistant chief, nursing education, VA Hospital, Danville, Ill. She was formerly instructor, VA Hospital, Salisbury, N.C.

Joseph Merlino, R.N. — has become assistant chief, nursing service, Brentwood Division, Los Angeles VA Hospital.

Leonard F. Stevens, R.N.—has become chief nurse, Jefferson Barracks (Mo.)

(Continued on page 65)



between "just white" and "just Right!"

Patients in over 4,000 hospitals give grateful thanks for DERMASSAGE—because there is a BIG difference between DERMASSAGE and similar-appearing lotion-type body rubs.

For over 21 years, this non-alcoholic hypo-allergenic emollient cream has aided measurably in the prevention of bed sores and skin chafe of patients confined to bed or wheel chair. Formulated like a fine pharmaceutical, DERMASSAGE confers certain special benefits not inherent in all massage adjuncts, for instance:

Lubricates the Skin, reduces dryness, skin cracks, irritations and hypersensitivity:

Facilitates Massage, avoids rapid evaporation, loss of skin moisture.

Reduces Bacteria, minimizes risk of initial infection.

Deodorizes and Refreshes, instantly relieves hot, burning skin—promotes soothing, comfortable relief, preserves acid mantle.

CONTAINS: Hexachlorophene, natural menthol, oxyquinoline sulphate, carbamide, water-soluble lanolin and olive oil in a homogeneous emollient lotion.

DERMASSAGE PLUS SILICONE—provides added protection against incontinence, drainage, perspiration, soaps, drugs, abrasion, etc. Binds therapeutic values of Dermassage to skin.

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easier for the surgical team
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half-round point
makes unique
"gape-incision"
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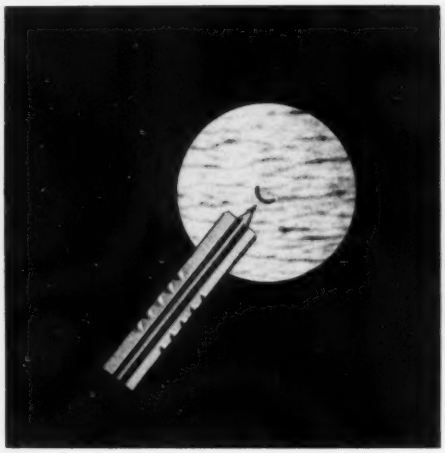
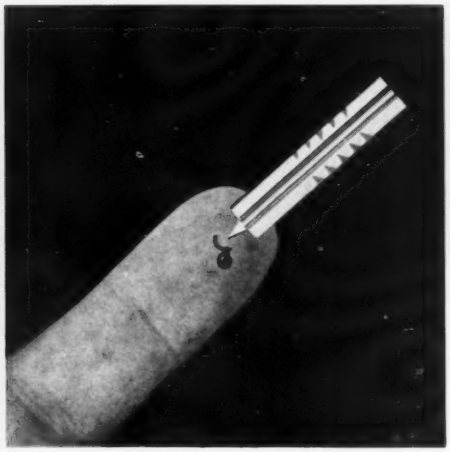
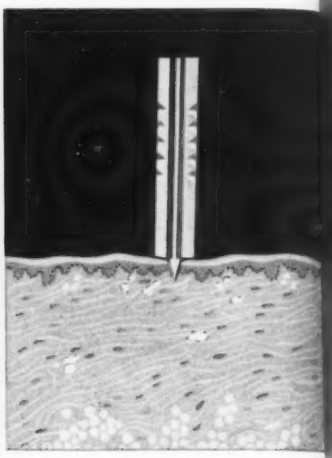
new

B-D sterile disposable blood lance

unique "gape-incision" gives you...







adequate blood flow

The new B-D LANCET produces a half-round incision that tends to pout or "gape"—avoids premature closure—clotting delayed.

Result—an easier and immediate yield of an adequate flow of blood.

minimal dilution

The "gape-incision" of the B-D LANCET makes "milking" of the finger tip unnecessary—just gentle pressure.

Result—a minimal dilution of the blood by tissue fluids—a truer specimen of the patient's blood.

controlled penetration

Side flanges of the B-D LANCET automatically control depth of penetration. The angle and length of the point ensures that incision is in region of densest capillary supply.

Result—easy penetration—fewer tactile corpuscles traumatized—minimal pain.

- **stainless steel—very thin, yet rigid**
- **sterile—ready for immediate use**
- **hermetically sealed in pre-formed foil**
- **translucent top for positive point location**

#P433 "100" PACKAGE — Consists of 5 aluminum canisters each having 20 individually sealed LANCETS and the B-D Tallquist Hemoglobin Scale.

#433 "250" PACKAGE—Consists of 50 strips of 5 LANCETS each, individually perforated.

BECTON, DICKINSON AND COMPANY

RUTHERFORD, N. J.

B-D, T.M. REG. U.S. PAT. OFF.

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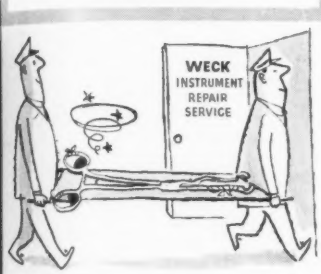
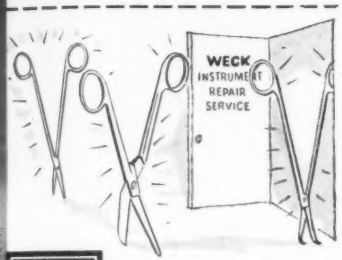
Send your "sick" instruments to the WECK "hospital"





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135 Johnson St., Bklyn 1, N. Y.

MEDICAL EMPLOYMENT SERVICE

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ANdover 3-5663 or 64
Alfred E. Riley, RN, MSHA, Director

ADMINISTRATORS: (a) 350 bed hosp., Midwest, Met. city, Sal. open; (b) 400 bed hosp., West, Sal. open; (c) 100 bed hosp., S. West, $6,000 per annum; (d) 100 bed hosp., Washington, Sal. $6,000; (e) 25 bed hosp., Texas, $7,200 per annum; (f) 300 bed hosp., New England, Sal. open; (g) 50 beds, South, $6,000.

ASSISTANT ADMINISTRATORS: (a) RN, Iowa, 50 bed hosp., $450 plus maint.; (b) 50 bed, N. West, $450; (c) 100 beds, West, $600 per month. Exp. in construction and engineering helpful; (d) 400 bed hosp., South; (e) 250 bed hosp., South, Sal. open.

DIRECTOR OF NURSES: (a) New Eng., Sal. open, Teaching hosp., M.S. degree. 300 beds. Excellent School of Nursing, progressive; (b) 400 bed hosp., S. West, School of Nursing, M.S. Degree, Sal. open; (c) Wisconsin, Catholic hosp. Excellent School of Nursing, Sal. open; (d) Ohio, 500 bed hosp. Excellent School of Nursing, M.S. degree req., Sal. open.

DIETITIANS: (a) Chief, South, 300 bed hosp., $450 per mo., 1 mo. vacation; (b) Chief, 150 bed hosp., Midwest, $400; (c) East, 200 beds, $400.

RECORD LIBRARIANS: (a) South, 100 beds, Sal. $400 per month; (b) Mid West, Chief, Sal. $400.

PHARMACISTS: (a) Chief, Ohio, Sal. open; (b) Chief, California, Sal. open.

PERSONALLY SPEAKING

(Continued from page 63)

VA Hospital, succeeding **Mrs. Mildred Caldwell**, who has become chief, nursing service, Atlanta (Ga.) Area Medical Office. Mr. Stevens was formerly chief nurse, VA Hospital, Salt Lake City, Utah.

New Officers

The Catholic Nurses of Kansas City-St. Joseph (Mo.) Diocesan Council have elected **Florence Golden**, Kansas City, president; **Mrs. Helen Simpson**, St. Joseph, vice-president; **Edna Sullivan**, St. Joseph, secretary, and **Claire Degan**, St. Joseph, treasurer. New officers of the Hospital Council of Southern California are: **George E. Peale**, superintendent, California Hospital, Los Angeles, president; **Sister Anne Lucy**, administrator, Daniel Freeman Hospital, Inglewood, vice-president; **Seymour Schulman**, administrator, City of Hope, Los Angeles, treasurer, and **William J. Daniels**, administrator, Hawthorne Community Hospital, recording secretary.

Maxine Hurley, Independence, was elected president, Missouri State Nurses' Association, succeeding **Dorothy Quigley**, St. Louis.

Lucille Becker, Mount Vernon, was elected vice-president.

Mrs. Sherrill Akyol, St. Louis, was named president, Missouri State Student Nurses' Association.

James A. Greene, M.D., Houston, Tex., has been installed as president, Texas Heart Association, succeeding **Dan D. Warren, M.D.**, Waco.

W. B. Adamson, M.D., Abilene, was named president-elect.

Other new officers are: **Robert E. Leslie, M.D.**, El Campo, and **Henry M. Winans, M.D.**, Dallas, vice-presidents; **Charles Bybee, M.D.**, Houston, secretary-treasurer; **Edgar M. Brown, M.D.**, Houston, executive director, and **Harold S. Foster**, Ft. Worth, chairman of the board.

William A. Kelly, M.D., has been elected president, Greater New York Hospital Association. He is director, Mount Vernon (N.Y.) Hospital.

Other officers elected were: **Fred K. Fish**, director, Lutheran Hospital, Brooklyn, president-elect; **A. A. Karan, M.D.**, director, Bronx Hospital, vice-president; **Louis Miller**, director, Jewish Memorial Hospital, New York City, treasurer.

(Continued on page 80)

Here's How LEGGE Safety Floor Maintenance SAVES YOU MONEY!

LEGGE suits the product to the job. And provides the Free services of a Safety Floor Specialist to see that the job is done right. The LEGGE Man surveys your floors for area, age, composition, condition and type of traffic before making his recommendations. He examines the equipment available. Then he works right with your crews.

He'll save you money—up to *33⅓%* on labor and materials. Your floors will look smarter, last longer. And he'll reduce slip accidents by up to *98%*.

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Ask to see our new movie, "Modern Floor Maintenance". Many administrative executives call it, "the finest training film ever". 16 mm., sound and color. Fill out coupon and we'll show it at your convenience.

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Firm_____
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City_____ Zone____ State_____

BUYER'S GUIDE

For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 80.

Barbara Work
Buyer's Guide Editor

300. Identification bracelets

Chieftain identification bracelets need no snaps, rivets, rosettes, tools or fasteners. Strap is pushed through opening and over hook until bracelet is snug on wrist or ankle. Strap is then pulled back, hook falls in nearest hole, and bracelet is permanently fastened. Supplied with pink, blue and white insert slips. Made of clear polyethylene, bracelets are available in infant and adult sizes. American Hospital Supply Corp.

301. Prophylactic garment

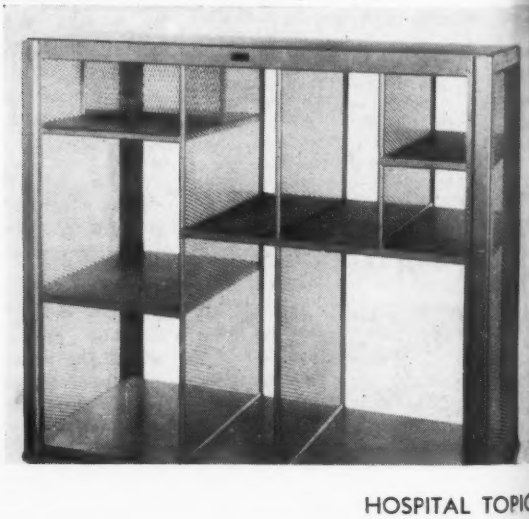
Pro-Pant protects bedding and clothing from the incontinent patient in senility, postoperative or congenital cases. Heat and acid resistant, garment is made of thin gauge plastic, lined with sanforized cotton flannel. Accommodates disposable absorbent pad. Elasticized at waist and thigh and fastened with stainless steel sna Washable, boilable, and bleachable. The Aztec Corp.

302. Pediatric examining table

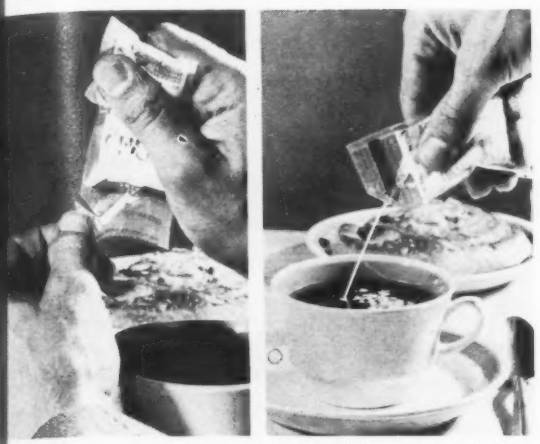
Pediatric examining table is 24″ x 40″ x 37½″, wi side and back rails of natural birch wood. A 15″ x drawer mounted in center under the top has steel sli and nylon rollers to prevent sticking of drawer. Ta is equipped with paper holder accommodating 18″ pap rolls, fed through slot in side rails. Lumex, Inc.

303. Linen cart

Fabricated from aircraft aluminum alloy, linen cart one-third the weight of stainless steel. Rolls ea on ballbearing, swivel, rubber-tired casters. Compar ment sizes are designed to fit every linen need. Carri enough linen in one load for ward of approximately persons. Bucks County Enterprises, Inc.

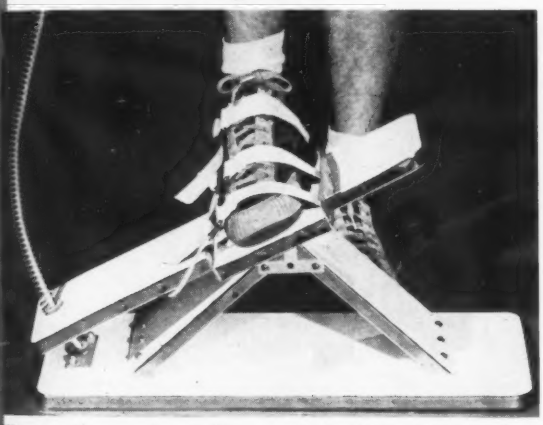


304. Cream packet



Three-quarter-ounce cream pouch with controlled flow spout and tear-off corner (left) gives user control over amount of cream used and prevents spilling. After spout is opened, cream does not begin to flow until flexible pouch is tightly squeezed. Flow stops instantly when pressure is released. Drops do not form or drip from open spout even though pouch is held spout downward. Polyethylene-cellophane combination withstands normal wear, tear or puncture action. Flexible even at sub-freezing temperatures; does not become brittle or tend to leak. Cheslam Corp.

305. Ankle strengthener



Therapeutic exerciser utilizes spring resistance for development of strength of the four stabilizing muscle groups of the ankle. Resistance is varied by changing length of resistor spring. No heavy weights to store, damage floor or cause injury. Easy-to-follow exercises included. Logan, Inc.

306. Stain remover

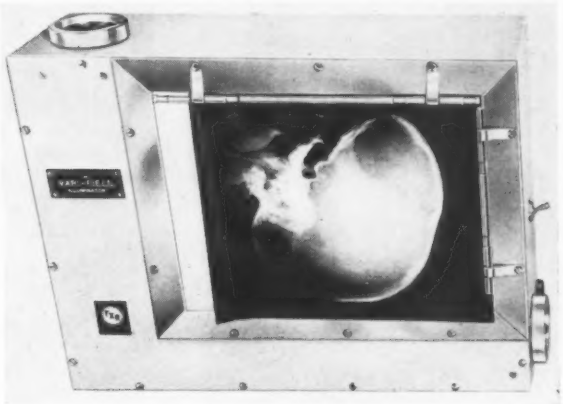
Plastic dishware stain remover adds lustre, removes stain and discoloration from all plastic dishware. Also removes odors of cabbage, sauerkraut, onion, garlic, etc., and stains on bathtubs, basins, crockery, drainboards, enamelware, marble, shower floors, sinks, and tile. Lightner Co.

307. Enamel

Super Dampcoat enamel paints safely over damp surfaces, has no odor to affect foods, is chemical resistant, and resistant to fungus attack, lime and strong alkali cleaners. Non-toxic, high gloss retention, hardens to porcelain-like finish in one week. Pearl gray, office green, sunlight yellow, gray green, light ivory, dado gray and white. The Wilbur & Williams Co.

308. X-ray illuminator

Vari-Field x-ray illuminator provides selective viewing of small x-ray film and reduces eye strain of operator. Views small radiographs up to 8"x10"; selects lighted viewing field from 2"x2" up to 8"x11". Can be used for vertical or horizontal viewing on a desk or installed as a wall mount. Electronics & X-Ray Div., F-R Machine Works, Inc.



309. Bronchoscope

New "Pentascope" can be used for examination, catheterization, biopsy, fulguration, and foreign body removal in all five lobes of lung. Consists of tube, light carrier and sheath, deflector and operating channel insert, and accessory collars and adapters. Accepts Jackson telescopes so that bronchoscopist can work under direct vision. Inside lumen is 6 mm.; diameter is 8 mm.; length, 40 cm. George P. Pilling and Son Co.

At the New England Hospital Assembly . . .

Mona Griffin (l.), obstetrical supervisor, Sceva Speare Memorial Hospital, Plymouth, N.H., and Evette Lafond, O.R.S., Truesdale Hospital, Fall River, Mass., ask G. S. Wallace, Liquid Carbonic Corp., about the new anesthesia regulator. The Liqui-Med two-stage regulator was designed for therapy and anesthesia in cases in which a uniform flow is required during diminishing cylinder pressure. It is equipped with two self-reseating safeties. 310C.

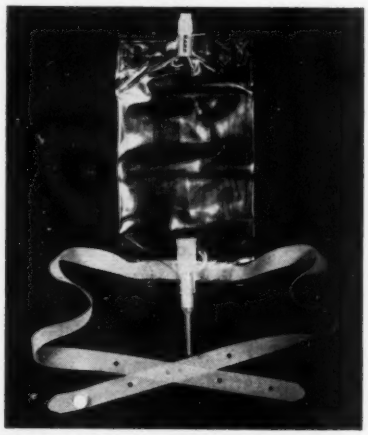
BUYER'S GUIDE

Continued

311. Instrument lubricant

Nurse prepares to dip surgical instruments in bath of "Surgical Instrument-Milk," a new non-oily substance for lubrication and rust protection of surgical instruments without bacteria-harboring oils. Protects instruments from rust so that even sharps can be autoclaved. Also keeps box locks free. Instruments are cleaned in regular manner, dipped in bath made from concentrate, drained for a few moments, then are ready for autoclaving. Snowden-Pencer Corp.

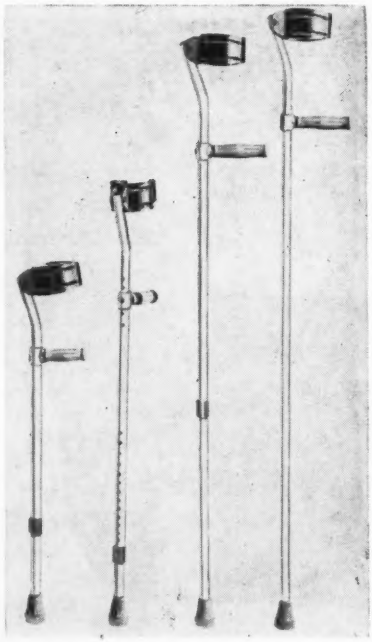
312. Bile bag



Plastic bile bag with nylon connector for "T" tubes from 12 through 20 is now available. Lightweight, flat bag comes sterile in transparent envelope, with latex strap for comfortable attachment of bag to the body. Flutter valve prevents return flow of bile. Bottom outlet enables bag to be emptied without detaching. Bag capacity is 26 oz. C. R. Bard, Inc.

313. Forearm crutches

Aluminaid forearm crutches feature wide range of length and hand-grip adjustments. Anodized finish complements all-aluminum construction.



Friction ferrule lock eliminates crutch extension wobble. Has double-ribbed forearm rest and crutch tip of metal-reinforced rubber. Available in Adult and Youth-Child adjustable sizes, plus non-adjustable, one piece custom model which can be cut to fit individual needs. Mah-Zell Precision Products Co.

314. Suction-ether unit

No. 900 suction and ether unit provides stand 15" wide, 11" deep, and 34" high from floor to table top. Has large accessories drawer, conductive rubber-tired casters, and stainless steel top fittings in chrome-plate. Bears Underwriters Laboratory Seal and C.S.A. for safety. Ether system has micrometer-type regulator indicating ether flow in liters per minute.

Aerovent Overflow Protection automatically prevents suction overflo Gomco Surgical Mfg. Corp.

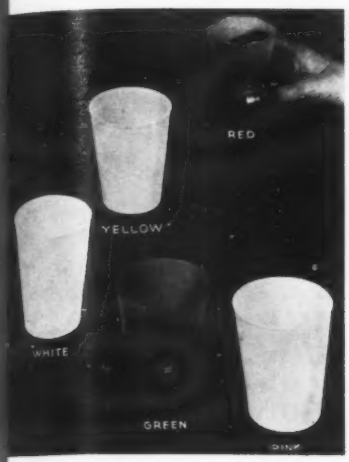
315. Arm traction frame

Side arm traction frame may be attached at any point alongside bed frame, including sections that may be elevated. Traction remains unchanged when back rest is raised or lowered. Frame may also be attached to end of bed for traction on leg or foot. Includes three arms of 27", 36" and 9" lengths, plus base clamp assembly, and a pulley and clamp assembly. Zimmer Mfg. Co.

316. Plastic tumblers

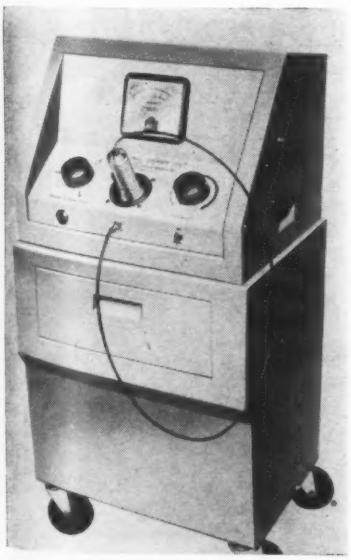
Single-service plastic tumblers for hot and cold drinks are now available at almost the low cost of paper hot cups. Made of 100 percent plastic,

ups are tasteless and odorless, and will not wilt or crumble. Available in five colors, in 7¼ and 9 oz. sizes. Busse Plastics.



317. Ultrasonic therapy unit

Ultrasonic therapy unit, model UM-600, provides accurately calibrated sound wave frequency of one million cycles per second for treatment of musculoskeletal conditions with ultrasonic energy. Dosage intensity up to three watts per sq. cm. is easily regulated by knob. Timer switch automatically shuts off machine at end of designated treatment period. Power control regulator holds power output constant regardless of variations in line voltage. American Cystoscope Makers, Inc.

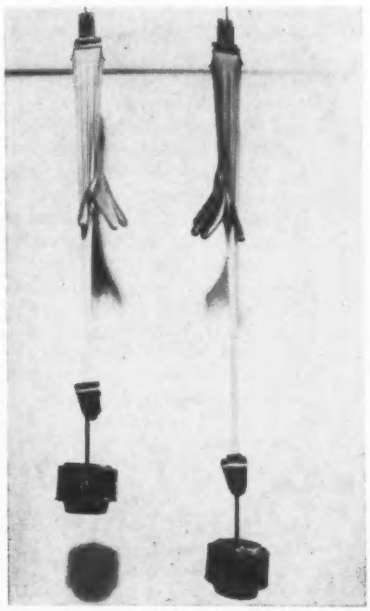


318. Diaper-panties

New diaper-panty combination is equipped with snap fasteners ad-

justable to six different positions on each side to accommodate infants from birth to 18 months. Knitted cotton bands at leg openings provide added comfort, absorbency and protection against cold. May be boiled like ordinary diapers, according to manufacturer. Open-end "pocket" allows insertion of extra cloth for added absorbency. Available in all white, and in pink, blue or maize with white leg bands. Quickee Diaper Panty Corp.

319. Surgeon's glove



New Sensitex surgeon's glove (r.) stretches farther under same weight as standard high quality surgeon's glove. According to manufacturer, glove is more sensitive to the touch and less tiring to the hands. In tests against other high quality surgeon's gloves, Sensitex glove before use proved to be 33 percent softer, 25 percent stronger, and to have 27 percent more elongation and 116 percent more tear resistance. After five sterilizations, the glove proved to be 56 percent softer, 64 percent stronger, and to have 28 percent more elongation and 170 percent more tear resistance. B. F. Goodrich Industrial Products Co.

320. Staining dish

Improved Columbia staining dish eliminates excessive evaporation of staining solution with use of non-breakable plastic, screw-tight cap. Cap has cork-backed foil liner that withstands organic solvents of all standard staining solutions. Inside of dish has four grooves to accommodate individual cover glasses or groups as large as eight, from 18 to 22 mm. in size. Mercer Glass Works, Inc.

At the New England Hospital Assembly . . .

John A. Swan (l.), administrator, Fairlawn Hospital, Worcester, Mass., is shown the utensil washer-sanitizer by H. Johnson, American Sterilizer Co. Utensils are automatically pre-rinsed for two minutes, are in the detergent six minutes, and get three post-wash rinses of eight minutes. 321C.

Product Trends at Tri-State

Exhibits which were shown at the recent Tri-State Hospital Assembly in Chicago are pictured on this and the following pages. If you wish additional information on any products shown, please send in the coupon on the Buyer's Guide card opposite page 80.

1

2

1. Bob Bays, Travenol Laboratories, Inc., tells Phyllis Thomson, central supply room head nurse, Regina (Saskatchewan) General Hospital, how medication can be added to parenteral solutions safely, quickly, easily and economically with Incert, one-step sterile additive vial. 335C.

2. Trying out the wheel chair is Rose Marie Wilmot, staff nurse, Schmitt Memorial Hospital, Beardstown, Ill., while Alice Pohl, anesthetist, also from Schmitt Memorial Hospital, and Emmett Brown, American Hospital Supply Corp., watch. Accessories on wheelchair include extra large swinging and telescopic foot-rests, swinging adjustable leg-rests, upholstered arm-rests, head-rest extension, and zipper back. 336C.

3. Lottie A. Hamilton (l.) and E. L. Kemmer, staff nurses, VA Hospital, Dwight, Ill., have their rings cleaned in ultrasonic cleaner, while Bill Sheppard, John Bunn Corp., explains how needles, syringes, instruments and glassware are cleaned with sound waves rather than detergents or alkaline cleaning agents. Syringes are sterilized in approximately four minutes, depending on size; needles in 15 minutes, and OR instruments in three minutes. 337C.

4. Examining hospital bedside chest of solid birch are Sr. Prima (l.), assistant administrator, and Sr. Assumpta, administrator, St. Mary's Hospital, Quincy, Ill. S. W. Carlson, Marshall Field & Co., Contract Division, tells them about formica top and sliding tray which provides working space for nurses. Top drawer can be locked, and space provided for patient's clothing. 338C.

5. W. B. Smith, Becton, Dickinson & Co., tells Esther J. Abbott, central supply supervisor, Chicago Wesley Memorial Hospital, about sterile disposable blood lancet in aluminum foil with glassine backing. Lancet has controlled depth, and gives half moon incision producing a free flow of blood. 339C.

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6. Discussing Ident-A-Bands are Martha Ann Bolalek, staff nurse, VA Research Hospital, Chicago, and C. M. Carpenter, Franklin C. Hollister Co. Pre-numbered Ident-A-Band of soft vinylite provides two identifications on each newborn and one section for mother's wrist. 340C.

7. Looking at combination pad are Sr. M. Thecla (l.), supervisor, and Sr. M. Arnold, x-ray supervisor, both of St. Francis Hospital, Milwaukee, Wis., and George L. Schumacher, Carolina Absorbent Cotton Co. Pad of cotton and cellulose in alternating layers provides maximum absorption through diffusion of drainage. 341C.

8. Explaining features of motorized hilow bed to Mrs. Mary Bolmer, executive housekeeper, Memorial Hospital, Elmhurst, Ill., is Bernard Tappa, Simmons Co. Bed is approved by Underwriters Laboratories for use with oxygen administration equipment of nasal type, mask type, and one-half bed length oxygen tents. All-steel bed takes all accessories. 342C.

9. O. H. Jones, Everest & Jennings, Inc., tells Sr. M. St. Barbara (l.), nursing instructor, and Sr. M. Venard, director of nursing service, Holy Family Hospital, Manitowoc, Wis., about the Rollator, lightweight walker which eliminates side motion. Available in four sizes and constructed of tubular steel, it will safely bear weight of heaviest patient. 343C.

10. San Pheno X, all purpose germicide, is the subject of conversation between M. D. Brown (l.), Huntington Laboratories, and George H. VanDusen, administrator, Christian Welfare Hospital, E. St. Louis, Ill. Germicide is safe on any surface unharmed by water. Will not irritate or sensitize skin, will not stain or corrode metal. 344C.

11. Looking at postoperative stretcher are (l. to r.): Mrs. Helen Morrison, board member, Brokaw Hospital, Bloomington-Normal, Ill.; Jack W. Bryson, Will Ross, Inc., Milwaukee, Wis.; R. W. Westerfield, Jarvis and Jarvis, Inc., and Herbert F. Preston, engineer, Brokaw Hospital. Stretcher has three positions, sponge rubber shoulder rests, adjustable back rest, removable end rail, and adjustable side rails. Electrically conductive throughout. 345C.

Trends at Tri-State

12. L. P. Gienko (l.), E. R. Squibb and Sons, tells James S. Butler, chief laboratory technician, Hammond-Henry District Hospital, Geneseo, Ill., and George Hamacher, chief technician, Lutheran Hospital, Moline, Ill., about Sumycin, new phosphate complex of tetracycline for faster and higher initial antibiotic blood levels. 346C.

13. Demonstrating new linen hamper to Harriet White, assistant director of nurses, University of Illinois Research and Educational Hospitals, Chicago, is Jack Martin, Advance Hospital Supply Co. 347C.

14. George Underwood, Smith and Underwood, shows Diack sterilizer controls to Margaret K. Poletzki (center), assistant supervisor, Physicians Service Bureau, and Esther F. O'Keef, supervisor, Physicians Service Bureau, Milwaukee (Wis.) County Hospital. Diack control is a fusible tablet hermetically sealed in glass tube 1¾" long. Tablet will not melt unless subjected to sterilizing temperature. 348C.

15. Robert D. Rowland, purchasing agent, Mt. Sinai Hospital, Cleveland, discusses folding aluminum service tray with Ben Marcus, Ar-Kay Industries, Inc. Patented safety locking mechanism for raising and lowering legs works with fingertip pressure. 349C.

16. Anne Phipps, supervisor, Peoria (Ill.) Municipal Tuberculosis Sanitarium, watches demonstration of blood pump by K. E. Brouwer, Abbott Laboratories. Disposable blood pump administration set permits instant switching from drip to pressure, with rate of drip always visible. Capacity of bulb-shaped pump is 30 cc. Check valve is between pump outlet and patient, with filter in the drip chamber. 350C.

17. Looking over literature on Damascus needles in Needletainers are (l. to r.): Sr. Joseph Ann, housekeeping department, Sr. Ladislos, staff nurse, and Sr. Ita, anesthetist, St. Margaret's Hospital, Spring Valley, Ill. David P. Housh, MacGregor Instrument Co., tells them about pre-sterilized hypodermic needles now available in individual reusable nylon case that protects the points. 351C.

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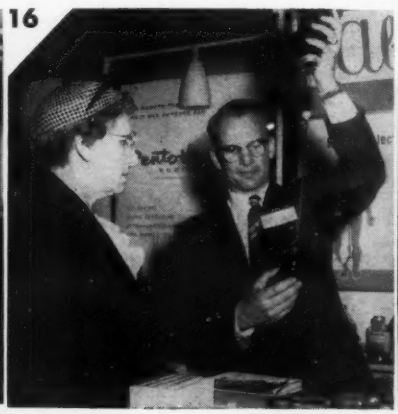

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18. Operating Hosp-I-Tell, silent call system, are William T. Dean, A. S. Aloe Co., and Tracie S. McMahon, director of nursing, Grand Rapids (Mich.) Osteopathic Hospital. Patient touches pushbutton on bedside unit to tell nurses' station his exact need. Ten different services, selected by hospital, are indicated on panel. Nurses' station signal can be turned off only in patient's room, thus assuring attention. 352C.

19. Applying Western Reserve pocket size inhalator and resuscitator to Mrs. Henry Hartmann, convention guest, is Jim Valentine, Continental Hospital Industries, Inc. Six liters of oxygen are released into rebreathing bag in seconds, by twists of wrist. Inhalator uses thumb size replaceable oxygen cylinders. 353C.

20. Dorothy W. Reiland (l.), O.R. head nurse, and Donna M. Hermes, O.R.S., St. Charles Hospital, Aurora, Ill., are interested in syringe and needle rack shown by George Ahearn, Edward Weck & Co., Inc. After use, syringes are disassembled with plungers, barrels and needles placed in rack in soak basin containing Weck cleaner. Needles are inserted in cellulose sponge. Procedure protects needles against damage, prevents drying of medication and blood, and reduces breakage. 354C.

21. Steripak, sterile nonadhering dressing, has caught the attention of Olga Elisa Ruiz, medical social worker, Mercy Hospital, Chicago, and Gretta M. Boylan, medical social worker, Mercy Clinic, Chicago. Robert H. Lee, Johnson & Johnson, remarks that Steripak is first completely patient-ready dressing. Available 4x4" and 8x4". 355C.

22. Chad Kelly, Cutter Laboratories, demonstrates Saftipump to Aluvia Harris (l.), O.R.S., and Charlotte B. Spines, director of nursing service and purchasing agent, Doctors Hospital, Milwaukee, Wis. Pump permits transfusion under pressure. 356C.

23. Admiring sanforized print are (l. to r.): R. J. Platte, administrator; Don M. Russell, auditor, Community Hospital, Clintonville, Wis.; Joe Marcel, Standard Textile Co., and Mrs. Russell, member, board of directors. Double print, 48" wide, has pattern on both sides. 357C.

Trends at Tri-State

24. Ed Gode, Mead Johnson & Co., shows sterile, nonpyrogenic cutdown infusion set, consisting of 8" length of polyethylene tubing and plastic Luer connector, to Charlotte Brooks, R.N. (l.), supervisor of surgery, and Rachel L. Bemiss, director of nurses, both of Fairview Hospital, LaPorte, Ind. 358C.

25. Operating glove testing and powdering machine for Sr. M. Trasilla (l.), assistant administrator, and Sr. M. Nicoletta, R.N., admitting office, Sacred Heart Sanitarium, Milwaukee, Wis., is Russell Ladd, McKesson Appliance Co. Glove is inflated by compressed air at same time as inside is powdered. Glove is dropped into plastic bag for outside powdering. Machine has three-position foot pedal control. 359C.

26. E. J. Schumaker, Adjustable Fixture Co., shows model 143, one of line of floor, bedside, examining, infra-red, ceiling, desk and table lamps, to Dolores May Drutowski (l.), staff nurse; Aurelia Stachowski, admitting office, and Elizabeth G. Bennett, supervisor, Johnston Municipal Hospital, Milwaukee, Wis. 360C.

27. Showing Curity suture packet to Marina G. Burns and Edita D. Aballera (r.), anesthetists, St. Mary of Nazareth Hospital, Chicago, is K. H. Oberlander, Bauer and Black. Laminated foil packet is hermetically sealed, and can be externally sterilized in formaldehyde jar solution without damaging suture. No glass to break. 361C.

28. Grace Cook, anesthetist; Barbara Kemp, R.N., central supply supervisor, and Fredonia L. Bourdon, purchasing agent, all from St. Joseph Mercy Hospital, Pontiac, Mich., are interested in Stryker PlasterVac demonstrated by O. M. Larson, G. A. Ingram Co. PlasterVac picks up dust as cast is cut. Durable, lightweight plastic hose is internally supported to prevent drag on cutter while in operation. 362C.

29. E. D. Barry, American Sterilizer Co., operates utensil washer-sanitizer for Mary Helen Anderson, assistant director, equipment and supplies, Presbyterian-St. Luke's Hospital, Chicago. Accommodates all standard utensils. Unit can be turned off and utensils removed at end of sanitizing steam cycle, or they may be left inside tub through drying cycle. Machine shuts off automatically at close of drying period. 363C.

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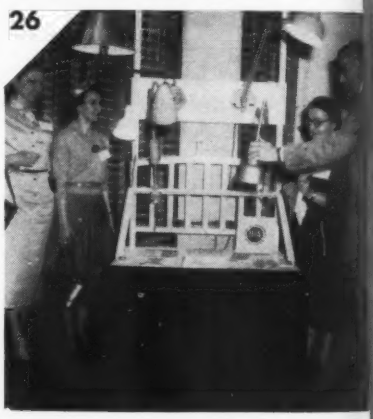

27

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FILMS AND NEW LITERATURE

380. Procedure manual

Procedure manual #3, "Hilow Beds," discusses manual and motor-driven beds, purposes, construction and engineering features, and use of accessories and related equipment. Hill-Rom Co.

381. Publicity program

Four-color circular shows how a dignified and economical public relations program for hospitals and medical institutions may be achieved through use of natural color postcards. Curt Teich & Co., Inc.

382. Equipment chart

Blue and yellow chart, 22½" x 16½", describes and illustrates parenteral solutions available, disposable IV equipment, and disposable blood collecting and transfusing equipment. Abbott Laboratories.

383. Laboratory catalog

Disposable, single use, sterile plastic labware are described in new catalog. Included are round, square and divided petri plates, box type culture dish, cups with cover or paper cap, culture tube, and filtering funnel. Falcon Plastics.

384. Hospital architecture

Attractive brochure illustrates use of stone in various styles of hospital architecture. Building Stone Institute.

385. Radioactivity measuring instruments

New 64-page, two-color catalog illustrates and describes over 30 radioactivity measuring instruments introduced since the last edition. Four-color insert pictures typical instrumentation for four medical radioisotope laboratories. Nuclear-Chicago Corp.

386. Hospital casework

Plastic-bound catalog on hospital casework and patient wardrobes gives complete specifications and suggested methods of assembling casework units. Is illustrated with installation pictures coordinated with architectural elevations. Maysteel Products, Inc.

387. Bacterial susceptibility film

Color film demonstrates methods of testing bacterial susceptibility to antibiotics, their advantages and limitations. The 26-minute film shows disc-plate and serial tube dilution tests and stresses pitfalls in interpretation. Pfizer Laboratories.

388. Unit fire detectors

Four-page illustrated brochure describes hermetically-sealed Detect-A-Fire units, which operate on rate-compensation principle. Detector actuates at selected protection level regardless of how slowly or rapidly surrounding temperature rises. Fenwal, Inc.

389. Prothrombin time film

Sound film strip in color describes theory, use and reporting of the prothrombin time test. "Determining Prothrombin Activity" gives recommended technics and means of avoiding error. Warner-Chilcott Laboratories.

390. Arthritis film

Uses of steroids in treatment of rheumatoid arthritis is subject of 16 mm. color motion picture, "'Meti' Steroids in Rheumatoid Arthritis." Chemistry, physiology and clinical application of the steroid hormones is reviewed, and the most commonly accepted theories of adrenal corticosteroid therapy are presented. Schering Corp.

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Items at Anesthesia Meeting

ABOVE, TOP: A. William Friend, M.D., executive secretary, International Anesthesia Research Society, and business manager, *Anesthesia and Analgesia* journal, compares notes on Xylocaine for infiltration and block anesthesia, and for topical anesthesia, with G. Vinton Hallock, M.D., Astra Pharmaceutical Products, Inc. 364C.

MIDDLE: George B. Lewis, M.D., anesthesiologist, Children's Hospital, Los Angeles; Edith Eason, M.D., anesthesiologist, St. Joseph Hospital, Chicago, and Kim Hallimore, E & J Mfg. Co., talk about cardiac monitor, battery-operated, explosion-proof meter for visual or aural monitoring. 365C.

BOTTOM: Anna Nicholson, M.D., anesthesiologist, Saskatoon, Saskatchewan, Can.; Les Frierdick, Burroughs Wellcome & Co.; Marie Hill, M.D., anesthesiologist, Rachel Foster Hospital, Sydney, Australia, and Ken Adcock, Burroughs Wellcome, discuss recent drug advances, of which Marezine, antiemetic, is a part. 366C.

On display at the Congress of International Anesthesia Research Society, held in Phoenix, Ariz., were the following items. For further information on any products, please check Buyer's Guide on opposite page 80.

BELOW: Robert T. Capps, M.D. (far right), anesthesiologist, University Hospital, Madison, Wis., is shown Ohio Chemical and Surgical Equipment Co.'s newest model. 367C.

BOTTOM: Howard A. Janneck (l.), Travenol Laboratories, tells Charles H. Gillespie, M.D., Scott & White Clinic, Temple, Tex., about Incert, one-step sterile additive vial. 368C.

ABOVE, TOP: W. F. Cormack (l.), anesthesiologist, Palomar Memorial Hospital, Escondido, Calif., looks over literature while Larry Schuck, Parke, Davis & Co., gives Gordon G. Fangsdorf, anesthesiologist, Scripps Memorial Hospital, La Jolla, Calif., information on Surital Sodium, intravenous anesthetic. 369C. MIDDLE: L. to r.: Oscar Schwidetzky, M.D., Becton, Dickinson & Co.; Dr. and Mrs. Foregger, New York; V. A. Stankiewicz, Foregger; L. Z. Kammer, M.D., anesthesiologist, Green Cross General Hospital, Cuyahoga Falls, O.; and John Wiles and George Pickering of Foregger talk about Foregger's latest unit. 370C. BOTTOM: William Stephenson, president, and W. B. Overhulse, Stephenson Corp., tell L. M. Taylor, M.D., anesthesiologist, St. Bernadine's Hospital, San Bernadino, Calif., the advantages of the Stephenson controlled respiration unit. 371C.

BELOW, TOP: Blood pump administration set is shown to H. Farquharson, M.D. (r.), anesthesiologist, Sequoia Hospital, Redwood City, Calif., by A. R. Murray and E. R. Coar, Abbott Laboratories. 372C. MIDDLE: Discussing Jefferson ventilator are John Stemerick, Air-Shields, Inc.; R. M. Lawerence, M.D., anesthesiologist, University of Rochester, New York, and Loren Walker, Air-Shields. 373C. BELOW, BOTTOM: David W. Owen and Martin Winokur, Winthrop Laboratories, Inc., tell Marvin F. Darsie, M.D. (r.), anesthesiologist, St. John's Hospital, Santa Monica, Calif., the advantages of Isuprel, new agent for anesthesiology, indicated in cardiac arrest, cardiac arrhythmias, ventricular fibrillation, laryngospasm, etc. 374C.

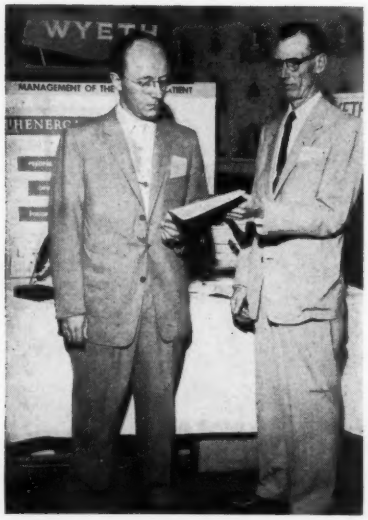
Items at Anesthesia Meeting

continued

Left: Looking over literature on Ether Squibb are: Wallace A. Reed, anesthesiologist, Phoenix, Ariz.; J. B. McKinney, anesthesiologist, Wichita Falls (Tex.) General Hospital, and G. A. Christopherson, E. R. Squibb & Sons. 375C.

Right: Joe Powell (l.), Merck, Sharp & Dohme, talks about Aramine, for acute hypotensive states associated with trauma, to Lt. O. H. Yarberry, Jr., U.S. Naval Hospital, Camp Pendleton, Calif., and soon to be anesthesiologist, Charity Hospital, New Orleans, La. 376C.

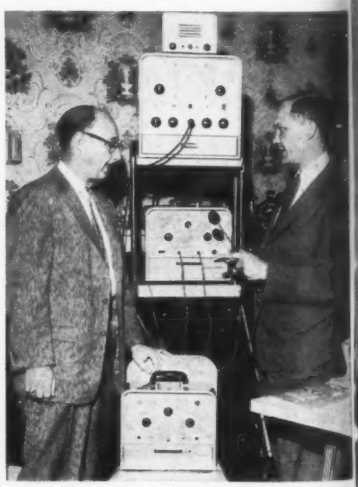
Right: Oscar Schwidetzky, M. D., (center), director of research, Becton, Dickinson & Co., shows Multifit Luer-Lok control syringe with interchangeable parts to T. H. Seldon (l.), M.D., program general chairman, and A. William Friend, executive secretary, International Anesthesia Research Society, while Bob Jungkind and Bob Piper (r.) of B-D look on. 379C.



Above: P. C. Lund (l.), anesthesiologist, Conemaugh Valley Memorial Hospital, Johnstown, Pa., learns more about Phenergan from Red Ahrendts, Wyeth, Inc. 377C.

Right: William W. Smith (l.), McKesson Appliance Co., demonstrates points anesthesiologists appreciate to LeRoy Tanuti and Bob Stark, Standard Surgical Supply Co., Phoenix, Ariz., who carry McKesson appliances. 378C.

Below: Al Dussing (r.), Dallons Laboratories, talks with William H. L. Dornette, M.D., assistant professor of anesthesiology, UCLA Medical Center, Los Angeles, about the cardioscope, defibrillator and cardiac pacemaker. 380C.



(Continued from page 61)

American Hospital Supply Elects Vice-Presidents

Erwin G. Kuchel, comptroller, and Edward W. Bangs, manager, Dallas sales division, have been elected vice-presidents, American Hospital Supply Corp.

Foster G. McGaw, founder, was re-elected chairman of the board, and Thomas G. Murdough was re-elected president. Other directors and officers also were re-elected.

News Briefs

Lynn Harrington — has become purchasing agent, Norwich Pharmacal Co. He was former chief, packaging department. **Samuel Leroy Nelson**—was recently named supervisor, southern division, with headquarters in Atlanta, Ga.

David Fielding Marsh, Ph.D. — 37, head of the pharmacology department, McNeil Laboratories, Inc., died April 1st.

Gen. J. Lawton Collins—former chief of staff, U.S. Army, has been elected to the board of directors, Chas. Pfizer & Co., Inc.

William J. Collins — will represent J. A. Deknatel & Son, Inc., in the Philadelphia area.

Ar-Kay Industries, Inc., received the Hospital Industries' Association bronze plaque for the outstanding technical exhibit at the recent Ohio Hospital Association convention. William E. Smith (l.), executive director, HIA, presents plaque to Russell Krapp, Ar-Kay Industries, while Wayne B. Foster, chairman of exhibits committee, looks on.

Charles F. Radley—has retired as director of publicity and member of the board of directors, Oakite Products, Inc. He is continuing as consultant on advertising, public relations and general management policy.

Instruments Division, Philips Electronics, Inc.—has opened a new office at 1825 Grant Ave., Philadelphia, to replace offices in Newark.

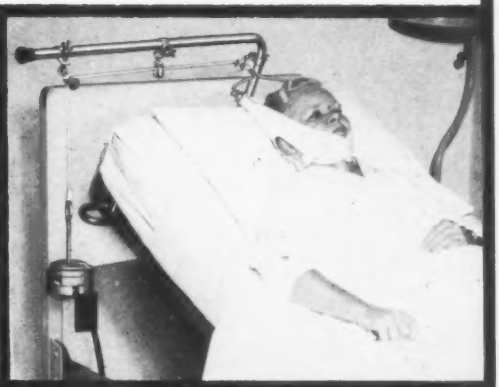
Homer Fritsch—executive vice-president, Parke, Davis & Co., died April 8. He was active as a member of the U.S. Committee of the World Medical Association.

New sales representatives, Hyland Laboratories, are: (seated, l. to r.), James V. Kelly, western Pennsylvania, eastern Ohio, West Virginia; Thomas Bellew, Michigan, western Ohio, northern Indiana; Robert L. Oligher, northern California, Utah, and Idaho. Standing (l. to r.): Frederick Lundgren, New England; Bob M. Hendon, Virginia and the Carolinas; William W. Moore, Georgia, Alabama and Florida.

CERVICAL+PELVIC TRACTION

WITH NEW DePuy TRACTION FRAME No. 700

Moves up with bed backrest!



This outstanding new frame can be quickly attached to any hospital bed. Supporting base clamps to bed spring frame, which permits elevating the entire frame with the backrest while cervical traction remains unchanged. The unit can be set up, as shown, eliminating the need for moving bed out from wall. Or, pulley-bar can be extended over head of bed if more convenient. For pelvic traction the unit is set up at foot of bed with pulley-bar inverted for greater height. Easy to use, sturdily constructed, folds flat for storage, and it's inexpensive. No. 700. Write for complete information!

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PERSONALLY SPEAKING

(Continued from page 65)

Deaths

Simon D. Ehrlich, M.D.—71, former director of anesthesiology, Beth Israel Hospital, founder and former president, American Society of Anesthesiologists, died recently.

Edward Francis, M.D.—85, tularemia identifier and developer of methods to combat it, died April 16 in Washington, D.C.

Ransom S. Hooker, M.D.—83, former director of surgery, Bellevue Hospital, New York City, and initiator of maternal mortality reforms, died recently.

Sister M. Patricia—84, former administrator, Our Lady of Lourdes Hospital, Pasco, Wash., died recently.

Sister Margaret Moore—night supervisor for 25 years, St. Elizabeth Hospital, Yakima, Wash., died recently.

Seymour Oppenheimer, M.D.—85, died April 21 in New York City. He was consulting otolaryngologist, Willard Parker Hospital, New York City, and consulting plastic surgeon at the Hospital for Joint Diseases, Bellevue Hospital, New York City, and Monmouth Memorial Hospital, Long Branch, N.J. He had also been chief ear, nose, and throat clinic, Mt. Sinai Hospital, New York City.

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Red Cross, FCDA Offer Special Nursing Course

A special nursing course, consisting of two seven-hour sessions, is being offered by the Red Cross and Federal Civil Defense Administration.

The course, a revision of former Red Cross training, was developed at the request of FCDA. Those completing the course will be called "Nursing Assistants."

Besides providing home care during an emergency, the assistants would be available for duty in hospitals, treatment stations, and other care facilities.

Graduate Course in Hematology Offered by University

A summer graduate course in comparative hematology will be offered for the first time by the biology department, St. Louis (Mo.) University, it was announced by John D. Dwyer, Ph.D., department director.

The five-week course, opening June 18, will be under direction of Sophie Jakowska, Ph.D., associate professor of biology, College of Mount St. Vincent, New York, N.Y.

The course, combining the biological and medical experimental approach to hematology, will carry two to three credits in the university's graduate program.

Application may be made through the university's graduate school.

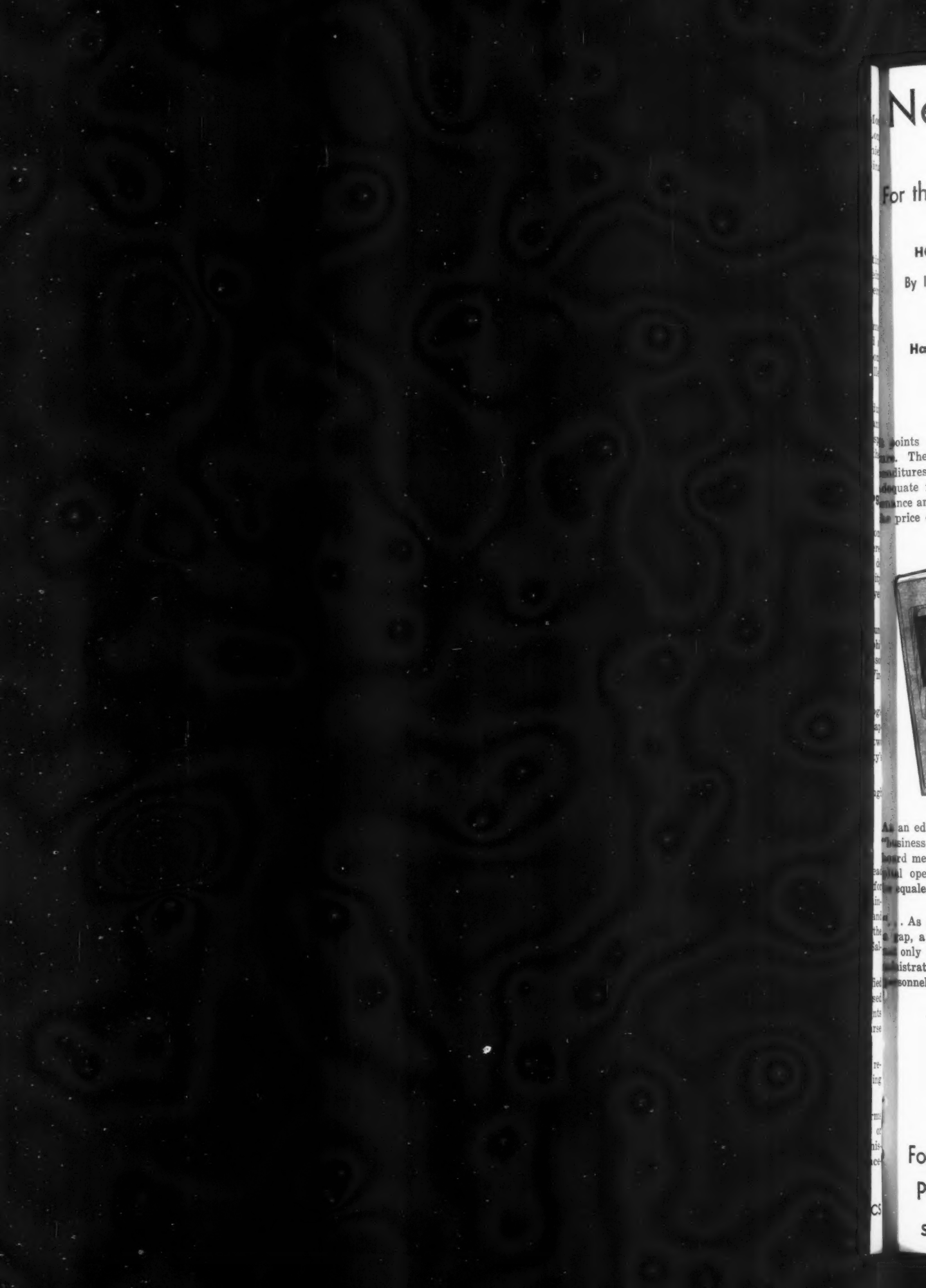
Seek Nurses for Duty In Indian Hospitals

An examination for staff nurse, head nurse, and public health nurse for duty in Indian hospitals located mainly west of the Mississippi river and in Alaska has been announced by the U.S. Civil Service Commission. Salaries range from $3,670 to $4,970.

Applicants must be fully qualified professional nurses currently licensed to practice. Senior nursing students expecting to complete their course within six months may also apply.

Public health nurse positions require additional public health nursing study.

Information and application forms may be obtained from post offices or from the U.S. Civil Service Commission, Washington 25, D.C., announcement No. 100-B.



New Books for the Hospital Staff

For the Administrator

HOSPITAL TRENDS

By Louis Block, Dr. P.H.

222 pages,
Handsomely Bound,
$5.00

points out the trends for the future. The chapters on controlling expenditures, budget, cost analysis, and adequate financial support for maintenance and operation are alone worth the price of the book.

As an educational tool to provide the "business-minded" trustee or advisory board member with the scope of hospital operations, it probably cannot be equaled.

". . . As a guide and reference it fills a gap, a long-felt need, in the field, not only for hospital trustees and administrators but for departmental personnel as well."

—*John R. McGibony, M.D.*, Professor of Medical and Hospital Administration, Graduate School of Public Health, University of Pittsburgh.

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SILENT SPOKESMAN—an Aid to the Speechless

By
Wayland W. Lessing

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309. Bronchoscope
310C. Anesthesia regulator
311. Instrument lubricant
312. Bile bag
313. Forearm crutches
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321C. Utensil washer-sanitizer

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349C. Service tray
350C. Blood pump
351C. Needletainers
352C. Silent call system
353C. Inhalator
354C. Needle rack
355C. Nonadhering dressing
356C. Saftipump
357C. Textiles
358C. Infusion set
359C. Glove testing machine
360C. Lamp
361C. Suture packet
362C. PlasterVac
363C. Utensil washer-sanitizer

INTERNATIONAL ANESTHESI RESEARCH SOCIETY

364C. Xylocaine
365C. Cardiac monitor
366C. Antiemetic
367C. Anesthesia machine
368C. Incert
369C. Intravenous anesthetic
370C. Anesthesia unit
371C. Controlled respiration unit
372C. Blood pump administration
373C. Ventilator
374C. Anesthesiology agent
375C. Ether
376C. Aramine
377C. Phenergan
378C. Anesthesia unit
379C. Control syringe
380C. Cardioscope

See other side for new book data.

NEW LITERATURE

380. Procedure manual
381. Publicity program
382. Equipment chart
383. Laboratory catalog
384. Hospital architecture
385. Radioactivity measuring instru
386. Hospital casework
387. Bacterial susceptibility film
388. Unit fire detectors
389. Prothrombin time film
390. Arthritis film

FROM THE ADS-BROCHURES

322A. Air-Shields, Inc., Dia-Pump fold
323A. A. S. Aloe Co., Infant Incubato brochure
324A. American Sterilizer Co., bulletins C-162, C-105
325A. Wilmot Castle Co., "Straightline milk formula sterilizer
326A. Doho Chemical Corp., Mallon D clinical data on Dermoplast
327A. Harold Supply Corp., Brochure
328A. Hausted Mfg. Co., information on Inval-Aid chairs
329A. Hill-Rom Co., Inc., Procedure Manual No. 2
330A. Lakeside Laboratories, Inc., Brochure No. NDA 17, Info
331A. Walter G. Legge Co., Inc., conductivity booklet
332A. The MacBick Co., CSR Data Fi for Architects
333A. Ohio Chemical & Surgical Equipment Co., suture catal
334A. Parke, Davis & Co., Surital Sodiu
391A. Shampaine Co., O.R. table
392A. R. A. Hawks Div., Sierra Engineering Co., catalog
393A. Edward Weck & Co., Inc., repri
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302	313	337C	348C	358C	368C	378C	387	328A	394A
303	314	338C	349C	359C	369C	379C	388	329A	395A
304	315	339C	350C	360C	370C	380C	389	330A	396A
305	316	340C	351C	361C	371C	380	390	331A	397A
306	317	341C	352C	362C	372C	381	322A	332A	398A
307	318	342C	353C	363C	373C	382	323A	333A	399A
308	319	343C	354C	364C	374C	383	324A	334A	399AB
309	320	344C	355C	365C	375C	384	325A	391A	399AC
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303	314	338C	349C	359C	369C	379C	388	329A	395A
304	315	339C	350C	360C	370C	380C	389	330A	396A
305	316	340C	351C	361C	371C	380	390	331A	397A
306	317	341C	352C	362C	372C	381	322A	332A	398A
307	318	342C	353C	363C	373C	382	323A	333A	399A
308	319	343C	354C	364C	374C	383	324A	334A	399AB
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[1]Grossman, Leo, St. Francis Hospital, Miami Beach, Fla., "A New Specific Treatment for Perianal Dermatitis", Arch. Ped., 71:173-79, June, 1955

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1. Alexander, Edythe L.: Mod. Hosp., May, 1957

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OB DEPARTMENT

Effect of Position on the Course Of the Second Stage of Labor*

By Michael Newton, M.D.**

Most physicians in this country are accustomed to conducting the second stage of labor with the mother in the lithotomy position. Its main advantage is that, when used in conjunction with the equipment of the modern delivery room, it is easier to insure asepsis, to handle obstetrical hemorrhage, to care for the newborn and to terminate the second stage of labor, when necessary, by means of forceps and episiotomy.

However, looked at from the perspective of history, this position is simply a newfangled fad. Sitting, kneeling, squatting, or other positions have been used for countless generations. Soranus' *Gynecology*, as recently translated by Dr. Oswei Temkin, contains a section on the construction and use of a "midwife's stool" or obstetrical chair as was employed in the second century A.D. In the middle ages, also, the obstetrical chair was an important adjunct to the practice of midwifery.

Even today many primitive women continue to deliver their babies in the sitting, squatting, or other positions. We have seen this at the University Hospital in Mississippi in women who have delivered several previous babies in their own cabins. Some of them want to kneel on the floor, and we have difficulty in persuading them that the delivery table is the proper place.

There can be no doubt that modern methods of obstetrical care have increased the safety of both mother and child. However, in discarding age-old positions for the second stage of labor, have we adopted a technic which is simply more convenient for the mother's attendants but less mechanically efficient and comfortable for the mother herself?

In considering this question, three problems present themselves. First, which position is more efficient for the expulsion of the baby? Secondly, if the sitting or squatting position is more efficient, can it be adapted to the demands of a modern delivery room? Thirdly, does the use of this position improve the management of the second and third stages of labor? The present study represents the preliminary phases of an attempt to answer these questions.

During the second stage of labor the mother's voluntary muscles of expulsion are used to augment the uterine contractions in pushing the baby down the lower birth canal. The muscles consist of the abdominal muscles, the diaphragm, and the accessory "straining muscles." In the sitting position when the back is curved, the force of these voluntary muscles is directed towards the pelvis. In the supine position, with the feet unsupported, part of their force is dissipated in pushing the abdominal wall forward.

An important corollary of this is that, when the expulsive muscles contract less efficiently, reciprocal relaxation of the muscles of the pelvic floor is also less efficient. In addition, gravity in the form of the abdominal contents and the weight of the baby is effective in the sitting or squatting position but not in the lithotomy position.

The same expulsive muscles are used, though to a lesser degree, in the everyday functions of defecation and urination. These functions are commonly and easily performed in the sitting or squatting position with the back curved. The greater efficiency of these positions will be apparent to anyone who has ever been compelled to make a bowel movement lying flat on a bed pan.

Thus it is reasonable to suppose that childbirth, like urination and defecation, is more efficiently accomplished sitting or squatting with the back curved.

The second problem is that of using these mechanical advantages in such a way that the ease of dealing with obstetrical problems is retained. The use of the traditional obstetrical chair would make it extremely difficult to secure asepsis, to control hemorrhage, or to use obstetrical forceps.

One solution to this problem, as has been done recently, is to raise the "obstetrical chair" in the air and thus permit the attendant to work under his patient.

A simpler method is to fit a backrest to the conventional delivery table. Such a backrest has been constructed for use in our department. It was made from inexpensive materials by the shop mechanic in our department of pharmacology. It is somewhat modified from a similar backrest used at the O'Connor and Franklin Hospitals in San Francisco. The idea for it came from Mrs. Mabel L.

(Continued on next page)

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**Dr. Newton is professor and chairman, Department of Obstetrics and Gynecology, The University of Mississippi Medical Center, Jackson, Miss.

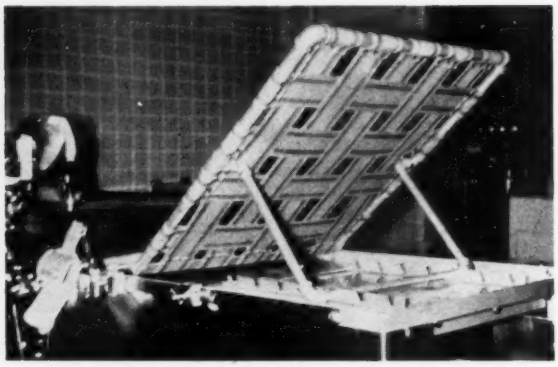


Fig. 1. Fitzhugh backrest fitted to delivery table.

Fitzhugh, a physical therapist, who has been greatly interested in education for childbirth in the San Francisco area for the past several years and who is working as a research associate in our department.

Figure 1 shows the Fitzhugh backrest in action. The curve of the mother's back should be noted. The angle of the backrest can be adjusted. Up to the present time we have used an angle of 20 to 40°, but this may not be enough, and we plan to increase this angle in future studies.

Until the head begins to show at the introitus, the legs are allowed to be free. In this way the patient can most effectively bear down by pulling on her own legs with her hands just below the knees.

When the stirrups are placed under the legs, they are lowered as far as possible, and care is taken to avoid separating the legs too widely. The foot plate is adjusted so that the mother can push hard with her feet but has no pressure under the knees. She can help herself by pulling on the handgrips. Whenever possible we prefer not to restrain the hands.

There is one important point to note about the position. The head is bent forward by a pillow. This helps to put the whole body in a curved line and increases the efficiency of the expulsive effort. During contractions the woman should be encouraged to flex her head still further.

The modified sitting position as produced by the backrest offers no difficulty in the use of procedures such as cleansing of the perineum, control of delivery, episiotomy, or the application of forceps. At first it was thought that anesthesia might represent a problem. It does so only if deep general anesthesia is required; then the supine position is of great help to the anesthetist. However, the vast majority of normal obstetrical patients do not require deep anesthesia, and when deep anesthesia is necessary the backrest can be put down easily and quickly.

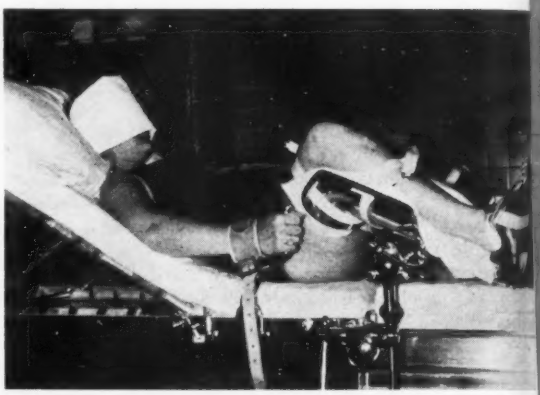
Evaluation of the effect of the semi-sitting position with the back curved on the second stage of labor represents a difficult problem, since many factors enter into it. At the present time we have data on the use of the backrest in 86 patients. These patients form part of a series of 220 patients followed consecutively at the University Hospital between February and May of 1956.

Various physical and psychological data were recorded for each of these patients, and a large number of them were interviewed in the immediate postpartum period. The details of the experimental method will be published elsewhere. Suffice it to say that the data sheets were constructed so that they could be placed on IBM cards for statistical evaluation. The sheets were filled in during or immediately after labor by the person who had had most contact with the woman during her labor and delivery, i.e., by the student or intern.

Records of the labors of these 86 women seem to us to indicate that the use of the backrest is entirely compatible with convenient and comfortable labor.

Most of the women progressed through the second stage of labor with little need for anesthesia. Only 14 percent had caudal, spinal, or nitrous oxide anesthesia. Twenty-six percent found that they needed whiffs of Trilene. More than half, 60 percent in fact, had no anesthesia at all or merely local infiltration or pudendal block. The result of this lack of anesthesia was that only three percent of the women were unconscious or deeply depressed at the time of delivery.

The great majority of women were self-controlled and cooperative during delivery. Only seven percent did not cooperate with requests and directions, and only eight percent screamed. The others responded to directions by the attendants part or all of the time, and were either quiet or made moderate vocalizations.



Position on delivery table in second stage of labor, with backrest raised, back curved, and head flexed.

The reaction to the baby was mostly a pleasant one. Only eight percent of the mothers were indifferent. None showed active disgust when they first saw the baby. The majority smiled a little, but 35 percent were greatly pleased.

The obstetrical details of the delivery were similarly normal. Forceps were used in less than a quarter of the cases. In only two percent were mid-forceps necessary.

Injury to the perineum was also low. Although episiotomies were not performed on 62 percent of the patients, only six percent had second-degree tears, and there were no third-degree tears. The third stage of labor was rapid, with only five percent having retention of the placenta for more than 20 minutes.

These records are quite similar to the other deliveries which took place in the University Hospital at this time. There is nothing to suggest that the backrest has an adverse effect on the second or third stages of labor.

The data so far available indicate that no disadvantages are apparent from the use of the backrest. A number of very favorable clinical impressions have come out of this investigation. These are:

(1) Increased comfort to the woman in the second stage. This is particularly noticeable when a patient is raised from the lithotomy to the propped position.

(2) Increased effectiveness of expulsion. This has been noted on a number of occasions when the backrest was raised in women who were making ineffective efforts during the second stage.

(3) Increased ability of the patient to see and hold her baby immediately after the delivery.

(4) Increased ability of the woman who has been educated for childbirth to cooperate, since she is not lying flat and "out of the picture."

Because our records show that there appear to be no adverse effects, and because of our favorable clinical impression, we plan to investigate the problem further.

We plan, during the coming year, to do a true experimental study in the second stage of labor, using comparable test and control groups.

New Mothers Sent Home With Formula 'Six-Pack'

● A 24-hour supply of infant formula in six ready-to-use sterilized bottles is now made available to mothers leaving Danbury (Conn.) Hospital with their new babies.

Mothers have always been given a supply of the baby's prescribed formula when going home, but until recently this went with them in a sterilized quart milk bottle. A service instituted recently made the formula available to them in nursing bottles, each containing the amount prescribed for one feeding. The bottles, having been sterilized before filling and again afterwards by the terminal heat method, are ready for immediate use as soon as warmed.

Word has spread about the convenient service, and most mothers inquire about it even before the nurse has had a chance to suggest it. A nominal charge is made which covers only the cost of the bottles. There is no charge for the formula.

Packaged much like the familiar supermarket "six-pack," and in a convenient carry-all labeled "For Baby," this ready-to-use formula supply is a real help for the new mother during the first hectic day back from the hospital.

Below: Nurse from Danbury (Conn.) Hospital presents new mother leaving hospital with a 24-hour supply of her baby's prescribed formula in six ready-to-use sterilized bottles.

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Grant to Aid Oklahoma Public Health Nurses

A $35,100 grant has been awarded by the American Journal of Nursing Co. to the University of Oklahoma, Norman, Okla., for a two-year study intended to improve professional qualifications and performance of Oklahoma public health nurses.

The grant makes possible a program of study for these nurses through the university's extension division.

The project will be conducted by the Extension Division and university's School of Nursing; the George Peabody College for Teachers in Nashville, Tenn., and the Division of Nursing, Oklahoma Department of Health. Co-sponsors are the Oklahoma State League for Nursing, Oklahoma State Nurses' Association, and state board of nursing.

Report Business Donations To Medical Schools

The National Fund for Medical Education annual report shows that business and industry contributed $1,862,016 in 1956 to the nation's 82 medical schools.

Of 1,737 companies contributing, 73 life insurance companies headed the list with $313,702. Pharmaceutical concerns were second with $198,205 from 51 firms.

Health Insurance Pays Half of Hospital Services

Voluntary health insurance, now carried by 70 percent of the population, pays for more than half the costs of all hospital services to insured and uninsured persons, the Health Information Foundation reports.

It pays more than 40 percent of the costs of all surgical operations, and more than 25 percent of physicians' fees in maternity cases, according to the report.

In 1956, $71.50 per capita was paid for medical expenses, with an average return of $27 each, or a total of $3 billion, from health insurance underwritten by Blue Cross, Blue Shield, and insurance companies.

'Patient-Governments' Useful In VA Mental Hospitals

"Patient-government" is useful in the treatment of mental illness because of the self-development, cooperation, and acceptance of responsibility it fosters, according to VA psychiatrists who are employing this technic in 30 VA hospitals.

There are two principal types of patient-governments. In one, ward patients elect several members as a council to represent the ward in joint meetings with hospital staff members. In the other, patients organize as a group similar to a community citizens' association, with a constitution, by-laws, and periodic meetings presided over by elected officers.

Patient-governments plan recreation, establish ward regulations for patients' conduct, assign housekeeping duties, and conduct other activities.

Although administrative procedures and relationships between patients and staff members often become improved, the main effect is to give patients opportunities for initiative, self-expression, and assuming responsibility.

Book Gives Averages on Nursing Salaries, Vacancies

Median annual salary for faculty members in schools of nursing was $4,140 in 1956, according to the 1957 edition, *Facts About Nursing*.

Salary figures were revealed in a survey of salaries and personnel policies for nursing educators in 73% schools of nursing (67 percent of all nursing schools) in the United States.

The book also reports that 14 percent of all full-time professional nursing positions in non-federal hospitals were unfilled last year.

Each institution averaged 7.5 full-time vacancies for professional nurses. Highest vacancy rates were reported in state or local government hospitals, and hospitals in the Middle Atlantic states.

Psychiatric Nursing Subject of Study

A two and one-half year project, initiated by a $12,420 grant from the National Institute of Mental Health, will be carried out by the National League for Nursing to determine how psychiatric nursing is now being taught, and how it should be taught in future undergraduate programs in collegiate schools of nursing.

Goldie Ruth Kaback, clinical psychologist and counselor trainer, New York City College, will administer the project, which will cost close to $100,000. It is expected to include psychiatric nurse-specialists, social scientists, psychiatric nurse educators, and nurse specialists in all clinical areas of the undergraduate curriculum.

Pediatrics

Florida's Poison Control Centers Give Good State Coverage

The idea of poisoning control centers, started primarily to combat accidental poisoning in childhood, has caught on rapidly throughout the nation since the first center was opened in Chicago a few years ago. But Florida is the first state to have a series of centers.

Fifteen centers, each serving an area from 25 to 100 miles, were established throughout the state in 1956. All centers are open to give information 24 hours a day. Any doctor or layman may call any center for information on the treatment of a poisoned person.

First plans for a poisoning control committee started in the Florida chapter of the American Academy of Pediatrics early in 1955. The Florida Pediatric Society decided to sponsor the project financially and do all the actual work in gathering and compiling information for the files. Before beginning this task, Florida pediatricians tried to acquire materials from other centers in the country, but found that none of them had anything equivalent.

"They either have someone heading (the center) who knows most of the answers, or they dig the information out of books or reprints," said Wesley S. Nock, M.D., president, Florida Pediatric Society.

Such a system, Florida pediatricians felt, would be all right in large cities, but would not work in their state because there would be centers in smaller cities in which a nurse would have to give the information because no doctor was available in the hospital on a round-the-clock basis.

Pediatric residents were hired to dig the information out of textbooks. A large grocery and market and two drug stores cooperated by making lists of all poisonous articles in their stores. All information was reviewed by the poisoning control committee before it was printed.

After the Florida Pediatric Society put $2,700 into the project, Mead Johnson and Co. gave a contribution so that the work might be continued.

The information which the committee assembled is filed in a double-drawer cabinet for 5" x 8" cards. In one drawer are white cards filed alphabetically (the identification file), and in the other drawer are yellow cards (the treatment file).

The identification cards are to help the physician ascertain the toxic ingredient in a poison-containing substance. Most of these cards are headed by common names or trade names, and list the toxic substance incorporated. Insects, fish, snakes, and plants are also listed, since poisoning problems involving these categories are not uncommon. The file includes products listed in *Accidental Poisoning in Childhood*, by Press (published by the American Academy of Pediatrics); *Handbook of Pediatric Emergencies*, by DeSanctis and Garga; Chapter 15 (by Jay Arena) in *Current Therapy*, and *Handbook of Poisons* by Dreisbach.

This section of the file will be increased periodically, depending especially on the types of poisons reported to the State Health Department.

The yellow, or treatment, cards are filed alphabetically by toxic substances. There are far fewer yellow cards than white, since obviously many products have the same toxic ingredient. Each yellow card contains information on the relative toxicity of the poison in question. As a rule, specific lethal doses are not given, since these are quite variable. Clinical signs and symptoms are given to help the physician follow the course of a particular toxic problem, and to determine the proper therapy. Many toxic substances have no specific antidotes, and must be treated symptomatically.

The entire card may be read off to a physician calling in, but it is recommended that a lay person calling be given only immediate first-aid treatment over the phone, and be asked to refer the patient to his own physician or have him brought to the poisoning control center for further treatment.

FILES FOR SALE

Because of many requests for copies of the file, poison center program officials decided to sell copies, at $85 each. Proceeds will help finance the program.

"We would have been willing to pay several times that much for such a file when we started, as it would have saved us many hours of work," Dr. Nock declared.

HOSPITAL'S ROLE IN CENTER

Specific objectives of a poisoning control center, as outlined in the manual of operations for Florida centers, are both improved treatment and increased preventive measures. The hospital's function in the center is:

(1) Diagnosis and treatment—making information available on a 24-hour-a-day basis to physicians treating cases of poisoning; providing actual treatment service—emergency outpatient service available on a 24-hour-a-day basis where requested by practicing physicians, for emergency cases, for indigent cases, or where the private physician is delayed; possibly doing research regarding the most effective treatment methods of poisoning.

(2) Prevention—compiling reports on the type of poisons encountered, with their response to treatment; providing periodic summaries and conferences for interested parties; contributing information to the central planning agency or committee which can be relayed to the public.

PEDIATRICIAN'S ROLE

The pediatrician in charge of the individual center has the following responsibilities:

(Continued on next page)

(1) To familiarize himself with the poison control facilities in the community—learn who are the most competent persons in the field of toxicology, pharmacology, industrial chemistry, botany, etc., and arrange to consult them when necessary.

(2) To see that the emergency room is equipped with the necessary drugs, appliances, equipment, and references to treat poisoning on a 24-hour-a-day basis, including periodic checks.

(3) To orient the intern, resident, or registered nurse on emergency-room duty to the fundamentals for routine treatment of poisoning and to see that the necessary reports are filled out and transmitted.

(4) To be on call (or have an alternate available) in cases in which the customary references and the routine directions are inadequate and further consultation is needed.

(5) To arrange periodic hospital conferences on poisoning, and serve as a liaison person along with other hospital control officers to the central committee or to another planning body in the community, and in general to be the "trouble-shooter" and "poison expert" in that particular hospital.

(6) To direct or arrange for a system of plans for the needed long-distance or local telephone calls or laboratory work involved in treating poisoning cases.

REPORTING CASES

Each case is supposed to be reported to the State Board of Health, to enable sharing of information on cases seen by the different centers. Case reports also will provide information on the occurrence of poisoning cases for all groups interested in accidental poisoning control.

EQUIPMENT

Emergency equipment recommended in the Florida manual for each center is as follows:

Stomach pumps, adult and child	Test tubes
Toomey and suction syringes	Glass pencil
Luer-lok syringes, 2, 5, 10, 20, and 50cc.	Pitcher
Aspirating and spinal puncture needles	Glasses
Assorted hypo needles	Alcohol lamp and needles
Airways	Endotracheal tubes
Nasal tubes	Levin tubes
Tube clamps	Lubricating jelly
Tongue clamps	Tongue depressors
Emesis basins	Applicators
Safety pins	Gauze flats
Tracheotomy set	Catheters
Gloves	Specimen bottles
	Glass slides
	Solution sets
	Cups
	Oxygen

IV fluids and equipment for administration—(1) sterile saline, 5% dextrose in water, molar lactate; (2) cut-down set; (3) hubless needles and three-way stopcocks; (4) armboards.

MEDICATIONS

Emergency medications listed are:

Acetic acid
Aminophylline
Activated charcoal
Amphetamine sulfate
Adrenalin
Amyl nitrate pearls
Amytal sodium
Apormorphine hypod. tablets
BAL (2, 3-dimercapto-propanol) in peanut oil with benzylbenzoate
Brewer's yeast
Bromobenzine
Caffeine sodium benzoate
Calcium EDTA
Calcium gluconate, 10% for IV administration
Calcium lactage solution for gastric lavage and oral and parenteral dosage
Camphor oil
Charcoal, activated—8-oz. bottles
Chloral hydrate—60cc. bottle
Codeine, phosphate hypod. tablets
Coramine ampules
Cortisone, vial
Cystine
Digitalis preparation (oral)
Digitalis preparation (parenteral)
Ephedrine hydrochloride
Ephedrine sulphate—ampules
Epinephrine (aqueous solution)
Glucose solution (sterile)
Ipecac syrup, 60cc. bottle
Lime water
Magnesium oxide
Magnesium sulphate (Epsom salt)
Methylene blue
Metrazol, ampules
Metrazol (cariozol) tablets
Milk, evaporated
Morphine sulphate hypod. tablets
Morphine sulphate solution
Mustard powder, 8-oz. bottle
Nalline, ampules
Neostigmine methylsulfate
Nikethamide (coramine)
Norepinephrine, ampules
Olive oil
Phenobarbital tablets
Picrotoxin
Pilocarpine hydrochloride hypod. tablets
Potassium chloride, ampules
Potassium permanganate solution (filtered)
Procaine amide (procain)
Procaine penicillin
Prostigum, ampules
Saline normal (sterile)
Sodium amytal
Sodium bicarbonate solid
Sodium formaldehyde sulfoxalate
Sodium nitrate solution, ampules 3 gm. in 10cc. of H_2O
Sodium thiosulfate solution, ampules 12.5 gm. in 50cc. H_2O
Sodium thiosulfate
Starch (corn powder 8-oz. bottle)
Tannic acid
Theophylline tablets
Thiamine hydrochloride, ampules
Tincture of opium
Vitamin B (thiamine hydrochloride)
Vitamin C (ascorbic acid)
Vitamin K (menadione).

Kerosene Poisoning*

By A. Bradley Soule, Jr., M.D.**

Between January 1, 1943, and December 31, 1956, 162 children were admitted to five hospitals following the accidental ingestion or aspiration of kerosene and two following the ingestion of red liquid furniture polish. Two children who swallowed kerosene and one who swallowed furniture polish died.

It is estimated that 40 or more additional cases of mild intoxication from kerosene were seen in this area by physicians in their offices or in the patients' homes. Similar experiences have been noted in many other parts of the United States, especially in rural and semirural

*Drugs accounted for 43 percent of the total cases of poisoning studied in a recent nationwide sampling on types of poisoning in pediatric practice, according to the Metropolitan Life Insurance Co. Kerosene came next, accounting for 16 percent of the cases.
**Burlington, Vt.

areas, in which kerosene and other forms of fuel oil are used for heating and cooking. From other published reports and from correspondence with physicians from various parts of the country and the world, it is apparent that the accidental ingestion of kerosene is the commonest form of poisoning in many of these areas.

None of the children was less than eight months old; only two were over two years old. In other words, they were old enough to be creeping or walking about the floor, but they appeared to acquire a distaste for kerosene or furniture polish at about the age of two.

Most of the children drank from glasses, cans, or bottles left on the floor to catch drippings from leaky fuel lines of oil stoves. One child sniffed kerosene from a drum from which the top was missing; another drank from a container in which paint brushes were soaking in kerosene; another drank from a cup of kerosene which the mother had been using in treating the child for nits.

Most of the victims were found on the floor, choking, coughing, gagging, or vomiting. Many became dyspneic within minutes; a number were drowsy or stuporous within an hour's time. About a quarter of them became cyanotic.

Of those children brought to the hospital, most had chest x-ray examinations on admission. Many of these showed clouding of basal segments of one or more lobes even within half an hour or an hour of admission. A few children were followed with serial chest radiographs an hour apart; in most instances, these showed signs of maximum involvement of the lungs in three to eight hours. *It seemed significant that all children who survived the first eight hours without alarming symptoms or extensive x-ray changes recovered promptly.* Clinical improvement was more rapid than radiologic improvement.

Many of the children vomited, and there was serious question in a number of cases as to whether the children aspirated vomitus, since they were frequently semi-stuporous. More than half of the children had gastric lavage performed on admission to the hospital. It seemed significant that a higher percentage of pneumonia changes, as identified clinically and radiologically, was noted in the group who had vomited than in those who had not vomited, and also in the group who had been treated with gastric lavage than in those who were not.

In the furniture-polish cases, the onset of severe symptoms was much slower than in the kerosene cases, with early x-ray signs of either clear lungs or over-aerated lung fields later followed by extensive and persistent clouding of central and basal segments. The toxic effects on the lungs, after they did appear, were much more prolonged, however, with inflammatory changes lasting for days or weeks. In other reported cases, the mortality rate from furniture-polish intoxication has been in the vicinity of 10 or 15 percent or higher.

In fatal cases of kerosene poisoning, death has resulted largely from the mechanical effects of filling-up of extensive areas of both lungs—the alveoli in these areas being airless and filled with a sero-sanguinous exudate including numerous oil droplets. "Asphyxial membranes" consisting of fibrin, leukocytes, and red blood cells lined the alveolar walls; small bronchial subdivisions were extensively involved with a broncho-pneumonic process.

Significantly, the apices and upper outer portions of the lungs were free from evidence of inflammatory change and contained no oil droplets—indicating a direct effect of the oil on bronchiolar and alveolar membranes from aspiration, rather than absorption of kerosene from the alimentary tract with hematogenous transfer

TREATMENT

For treatment, oxygen was especially useful and was used routinely when cyanosis or dyspnea was present. Antibiotics were used to combat infection.

Experimental studies on rabbits, cats, and dogs have indicated that intratracheal administration of even minute quantities of kerosene produced a rapidly fulminating and usually fatal broncho-pneumonia of the type seen in the fatal cases in children. Intragastric administration of kerosene failed to produce pneumonitis in dogs unless the dogs vomited, when a certain number of them developed what appeared to be an aspiration type of bronchopneumonia in dependent portions of the lungs. In smaller animals, intragastric administration of kerosene produced general systemic and cerebral depression and death if sufficiently large quantities were introduced.

It is the impression of the author and of a number of other workers that pneumonitis is rarely, if ever, produced by absorption of kerosene from the alimentary tract, but is usually the result of direct aspiration during a choking attack when the child tries to swallow it, or from aspiration of gastric contents (including kerosene) during vomiting or gastric lavage. It seems doubtful that the average child will swallow enough kerosene to produce fatal effects from absorption of toxic substances alone. However, kerosene is a crude substance of highly variable composition, and it is possible that in certain cases it may contain impurities which may be poisonous.

The use of gastric lavage is one of the most controversial features of the treatment of kerosene poisoning. Although most of the children in our series were treated in the earlier years of our study with gastric lavage, the trend in recent years has been to resort less and less to this procedure, especially if the child shows little or no evidence of toxicity when first seen.

It has seemed to many, including ourselves, that in most cases the risk of leaving kerosene in the stomach is less than the subjection of the children to the passing of a stomach tube with consequent danger of aspiration of kerosene in gastric contents during the procedure. Moreover, very little kerosene is usually recovered in performing lavage. Finally, none of the children in our series on whom gastric lavage has been omitted have died or developed alarming symptoms.

Studies are being made in a number of communities in which kerosene poisoning is common, in which lavage has either been abandoned or is being done on alternate hospital admissions. Until these studies have been evaluated, one must reserve judgment on the wisdom of gastric lavage as a routine measure.

Education of the public as to the dangers of kerosene and liquid furniture polish to young children is of paramount importance. Unfortunately, the conventional instruments for dissemination of information—newspapers, magazines, radio, and television—have not been overly effective to date, principally because this type of poisoning occurs usually in the low-income group.

It is also suggested that kerosene be retailed only in distinctive standardized metal containers with spouts, lips, and handles which are so made as to allow easy adult use but which would be difficult for small children to handle. Containers should be clearly labeled as both flammable and poisonous. A repellent color such as blue might be used to distinguish kerosene from water or other safe liquids.

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It used to be that preparing and giving those routine enemas topped my list of "Most Unpleasant Nursing Chores." But, with Enemol — it's so much easier and faster that I don't mind it nearly as much.

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Enemol ***is the only disposable enema*** I know of, with a shut-off valve you can easily open and close with a simple twist. You can even clear air from the tube before inserting. The tube, with its soft round top, is just stiff and long enough (6 inches) to insert easily without hurting the patient.

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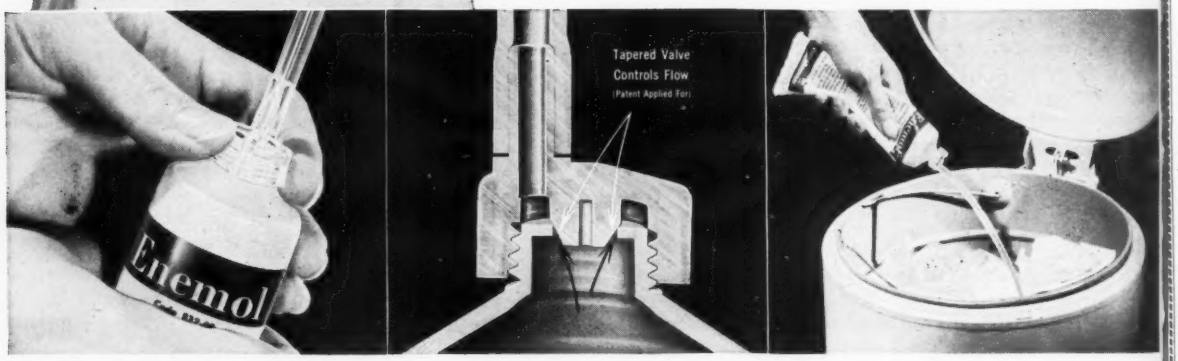

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HOSPITAL Topics

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Official bulletin for the
Association of Operating Room Nurses

To Fellow Members of the AORN:

At our fourth annual congress, held February 18-20 at the Statler Hotel in Los Angeles, you honored me by electing me your president. I accepted the office with gratitude and in all humility.

I am aware, as I know you are, that ours is a young organization. We are only starting on the road to accomplishment of the purpose for which we were organized: to make us all better operating room nurses and to help us provide the finest care in surgery for the patients who are our special charges.

Ours is and should be a democratic organization. All members should have a voice in its affairs. To that end, I welcome any suggestions that you may wish to send me as to how we, collectively, and I, as your president, with your officers and directors, can accomplish these objectives.

No chain is any stronger than its weakest link. Therefore, every member of this association should not only participate to the extent of her time and ability in association affairs, but should contribute in any way she can to the general well-being of the organization and all its members. We get out of anything worthwhile only what we put into it. That is true of our association.

Why not encourage your co-workers to join the AORN by paying $1 national dues through your local group? If there is no local group, dues may be sent directly to national headquarters, 305 W. 18th St., New York 11, N. Y.

We have a glorious future ahead of us. It is, at the same time, a challenge which we must meet courageously. There is an opportunity for us to add luster to the proud history of our chosen profession and to place the Association of Operating Room Nurses on a par with every professional organization dedicated to better health for the American people.

I am certain that I can count on your loyal support and again wish to thank you for the honor you have conferred on me.

Sincerely,

Pauline R. Young

Pauline R. Young, President
Association of Operating Room Nurses

Use of Pump Oxygenator In Cardiac Surgery

By Marie B. Ellison, R.N.*

● During the past decade rapid progress has been made in cardiac surgery, and today its place is firmly established in hospitals throughout the country. Although developments in this field until the present have been remarkable and impressive, the scope of intracardiac surgery has been limited by the inability to actually visualize the lesions inside the cardiac chambers for surgical repair. Thus, the recent development of an effective mechanical heart-lung for temporary cardiopulmonary by-pass which provides a means of open-heart surgery removes a major barrier to future advances in cardiac surgery.

This revolutionary method is gaining popularity in a number of medical centers, and in our institution some 100 operations of this type have already been performed with exciting and gratifying results.

The principle upon which the method is based consists of removing the unoxygenated venous blood from the vena cavae, pumping it through a mechanical oxygenator, and returning the oxygenated blood to the arterial system (Figure 1). The function of the heart and lungs is therefore replaced temporarily so that the heart may be opened for surgical repair of a variety of intracardiac defects. After the defect is repaired, the mechanical pump is discontinued, and cardiac function resumes.

Frequently complete cardiac standstill may be desired during the intracardiac repair, and this may be obtained by injection of solutions of cardioplegic agent such as potassium citrate, potassium chloride, or acetyl choline into the ascending aorta (Figure 1). These solutions perfuse the coronary arteries, and complete cessation of cardiac action results. At the completion of the intracardiac procedure the clamp is released from the ascending aorta, the cardioplegic agent is washed out of the coronary system, and cardiac action recovers.

From this brief description of the system one must not assume that this method is simple to perform. Quite the contrary. The responsibilities on the nurses as well as the surgeons are much greater than in any other major surgical procedure being done at the present time. Success depends upon teamwork, efficiency, and understanding of the principle and problems which may be encountered.

In our operating rooms the surgeons provide certain services which are not expected of them under ordinary circumstances. In these operations we employ a stainless steel oxygenator designed by the team of doctors who are actively engaged in this project (Figure 2). The oxygenator is based upon the bubble-diffusion principle, so that the unoxygenated venous blood is mixed with oxygen in a central diffusion chamber. In a chamber which contains stainless steel mesh coated with Dow-Corning Antifoam A, a silicone substance, the oxygenated blood is defoamed and converted back to a liquid state and enters the collecting reservoir after passing down a declined trough. The oxygenated blood may then be returned to the patient by way of the pump.

Assembly of the oxygenator is the responsibility of a surgical technician employed by the Baylor University College of Medicine. After each procedure he dismantles the oxygenator and washes it thoroughly with tap water and Haemosol, cleaning the perforated

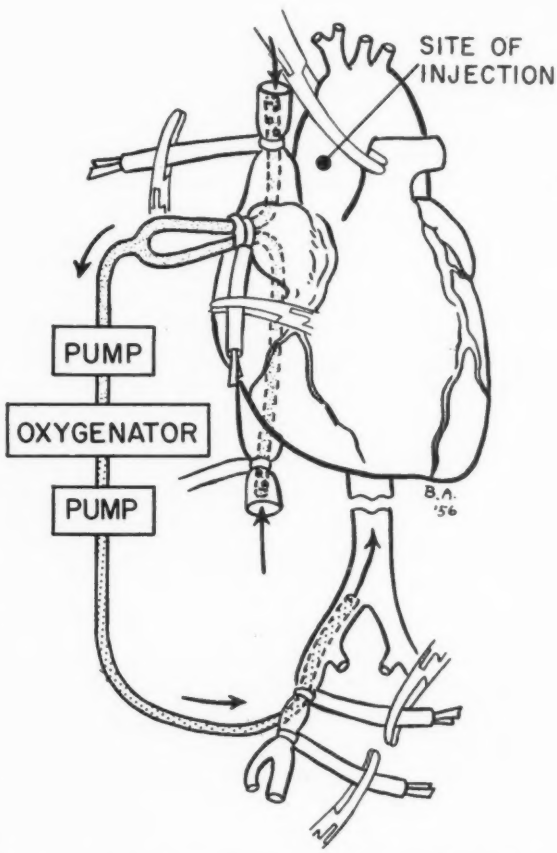
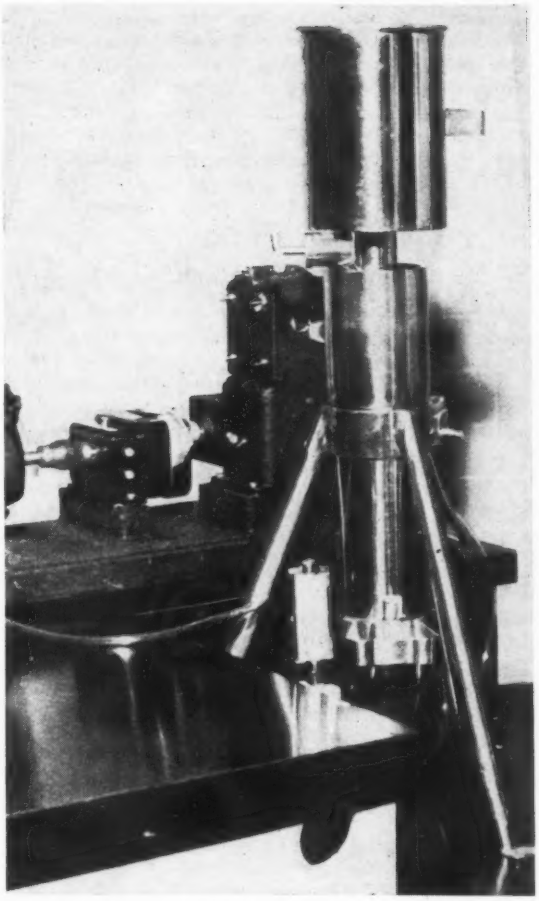


Fig. 1. Diagram showing general method of cardiopulmonary by-pass using a pump oxygenator system. This method provides conditions permitting intracardiac surgery under direct vision. Injection of potassium solution into the ascending aorta produces complete cardiac standstill during the repair of the cardiac defect.

*Supervisor of operating rooms, St. Luke's Episcopal and Texas Children's Hospitals, Texas Medical Center, Houston, Tex.



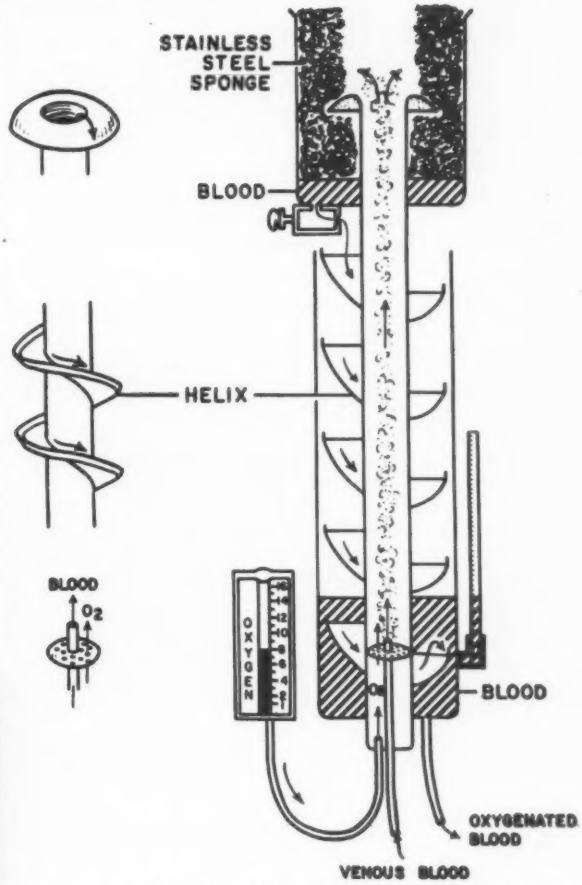


Fig. 2. Photograph and explanatory diagram of stainless steel oxygenator of a bubble diffusion type used in cardiopulmonary by-pass.

diffusion plate carefully with hydrogen peroxide solution.** The oxygenator is carefully dried, reassembled, and wrapped for autoclaving usually on the day preceding operation.

Just prior to operation the technician removes the oxygenator from the wraps and places it on a separate table covered with sterile sheets. The stainless steel sponge is coated with the antifoam substance and placed in the defoaming chamber. Connections of sterile plastic tubings are made at the base of the oxygenator, and the oxygenator is placed in the tripod stand ready for use. Other connections are made using sterile polyvinyl plastic tubing and catheters to complete the circuit (Figure 1).

The tubing used for the connections is usually of $\frac{5}{16}$" internal diameter, and is available commercially in sterile sealed packages. It was originally designed for connection with drainage bottles. The tubing is used only once and is discarded after operation. Therefore, all of the supplies concerned with the pump oxygenator are provided by the surgeon and his staff.

OPERATING ROOM NURSE'S RESPONSIBILITY

Although the actual setting up and operation of the pump oxygenator are not the direct responsibility of the operating room nurse, she must play a vital role during the entire procedure. It seems fair to state that never before has so much been expected of the operating room nurse as in this procedure. Since the project is quite new, technics are constantly subject to change, and willingness, understanding, and cooperation from the nurse are extremely important.

Actually, two operations are being performed simultaneously in the one operating room, and even though the room may be of adequate size for other types of surgery, under these circumstances space may be strictly limited, adding a challenge to the circulating and scrub nurse to supply sterile materials for both tables without confusion and breaks in sterile technic. An intelligent, versatile nurse with a pleasant personality and even disposition is necessary to the successful performance of the procedure.

Certain points deserve mention and should be noted, since these have been fairly routinely involved in all of the procedures:

1. A veno section is always done before the operation, the ankle being the most frequent site.

2. A femoral incision is always made to insert the cannula for return of the oxygenated blood. The femoral region must therefore be surgically prepared.

(Continued on next page)

**Distilled water could be used to prevent deposition of crust from mineral salts, to remove pyrogen, etc. The author says that tap water is used because it is more convenient and that peroxide is employed to guard against these undesirable results.—ED.

3. A bilateral anterior thoracotomy incision is used transecting the sternum; so the entire chest must be prepared.

4. The electrical defibrillator must be checked and ready for use with the sterile electrodes opened and connected. Ventriculur fibrillation is a frequent complication of these procedures and must be corrected quickly.

5. The pump is primed with fresh heparinized blood which is drawn from donors on the morning of surgery and must be maintained at body temperature in a basin of warm water. This blood must not be mixed up or mistaken for the citrated blood which is used for transfusion but never in the pump itself.

6. Some drugs must always be available on the table in labeled syringes, such as potassium citrate solution (prepared by the pharmacist), calcium chloride, heparin, and protamine sulfate. Other routine drugs must be available, such as atropine, epinephrine, procaine amide, etc., but need not be on the table.

7. Repair of the defect will require silk sutures 4-0, 3-0, or 2-0 with incorporated needles depending upon the size of the patient and the size of the defect. For very large defects, usually of the ventricular septum, polyvinyl sponge or nylon-dacron knitted cloth has been used either as a tampon or patch to close the opening. (Figure 3).

Acknowledgment is made to Denton A. Cooley, M.D., Associate Professor of Surgery, Baylor University College of Medicine, for assistance in preparation of this report.

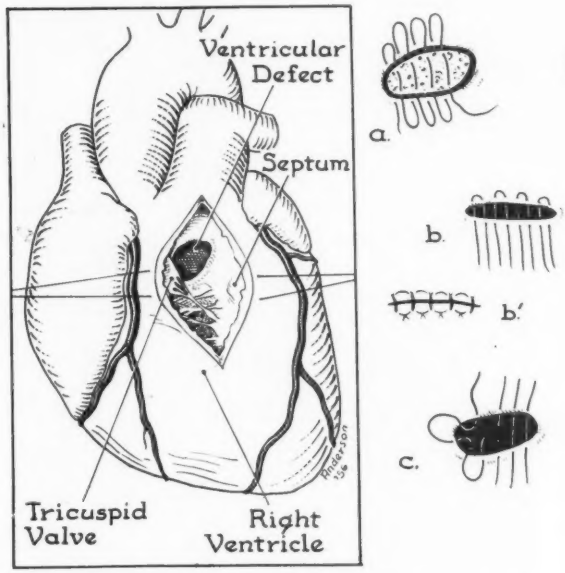


Fig. 3. Drawing showing the surgical exposure of a ventricular septal defect and the methods of surgical repair which have been used, including simple suture or the use of polyvinyl sponge or knitted nylon-dacron cloth as a patch over the defect.

Cardiac Arrest And Resuscitation

By William P. Mikkelsen, M.D.*

● Until recently, most unexpected fatalities occurring in the operating room have been designated as anesthetic deaths. Now there is developing an increasing awareness that in many such instances "death" followed ventricular asystole, and it is now recognized that prompt and correct management of this problem will frequently be rewarded by complete recovery of the patient.

The terms death and ventricular asystole thus are obviously not synonyms. The frequent confusion of these two terms is dependent upon the failure to recognize that under such circumstances death involves not only the existence of ventricular asystole, but also the continuation of this condition for a period of minutes required for progressive hypoxia to produce lethal systemic damage.

It must be noted further that ventricular asystole may be due to factors other than anesthetic. And certainly there are instances of irreversible and unpreventable ventricular asystole occurring on the operating table that represent death attributable to a distinct disease process itself.

Because of these foregoing considerations, consistent analysis of such problems requires a definition of cardiac arrest. Such a definition has never adequately been developed, nor is there consistent agreement among physicians as to just what constitutes this process. A practical definition is: Cardiac arrest is potentially avoidable, usually reversible ventricular asystole, with or without fibrillation, precipitated by the effects of anesthesia or surgery, either alone or in combination. Excluded from this definition are those instances of fatal ventricular asystole occurring in the operating room in which the disease process was so severe that the physiopathologic mechanisms were irreversible or in which uncontrollable conditions such as fatal myocardial or pulmonary infarction occurred.

It should be emphasized that cases of cardiac arrest are not due to some mysterious entity, but rather that a diligent search will almost always reveal etiologic factors conditioning the development of this catastrophe.

*From the Department of Surgery, University of Southern California School of Medicine, Los Angeles. This paper and the one following, by Gloria Castillo, R.N., were presented at the fourth annual congress, Asssociation of Operating Room Nurses, Los Angeles, February 18-20, 1957.

In the investigation of the individual case it must be borne in mind that the anesthetic agents employed are all potentially lethal, as are many of the complicated surgical technics necessary to permit alleviation of disease processes. Under these circumstances a narrow margin of safety often prevails, so that even a small human error in judgment may produce a fatal result. The surgical procedure itself may be capable of producing physiologic disturbances such as hypoxia, which are in essence the same as those that may result from the anesthesia.

A feeling of mutual responsibility should exist among the members of the operating room team to see that optimum conditions for the patient's safety prevail at the time he arrives in the operating room. Good judgment and careful management should continue throughout the anesthetic and surgical procedures. Such mutual responsibility is necessary in order to limit the occurrence of cardiac arrest.

ETIOLOGY OF CARDIAC ARREST

The factors that precipitate cardiac arrest in the operating room are numerous and varied and involve such general categories as respiratory, cardiovascular-hematologic, metabolic, pharmacologic, and neurogenic-psychologic. In an analysis at the Los Angeles County Hospital it was found that the predominant causes for cardiac arrest were asphyxia, relative overdose of anesthetic agent, inadequate preoperative preparation of the patient, and operative hemorrhage. These four categories accounted for 89 percent of the arrests that occurred in this hospital during the four-year period from 1951 to 1954 inclusive.

During this time there were 82 instances of cardiac arrest, of which only 17 were successfully resuscitated. The incidence of cardiac arrest in this hospital was approximately one in every 585 operations.

It is true that many of these patients had severe disease, and the margin of safety with which the anesthetist and surgeon had to deal was small. Perhaps in some this margin of safety was so small that their deaths might have been more appropriately considered attributable to disease. However, in each case one or more avoidable mechanisms for cardiac arrest could be detected.

No field or specialty of surgery was exempt. Cardiac arrests occurred during urologic, orthopedic, thoracic, neurosurgical, plastic, otolaryngologic and ophthalmologic procedures, but predominated in patients having abdominal operations.

PREVENTION AND TREATMENT OF CARDIAC ARREST

Recognizing the need for improvement in the problem of cardiac arrest, the Los Angeles County Heart Association established a committee on cardiac resuscitation in 1952. The primary function of this committee was to provide information on this subject to all operating room personnel in the Los Angeles area. A group of physicians from the committee presented information on cardiac arrest at staff meetings of each hospital.

On each hospital staff one or two surgeons were designated to coordinate the hospital activities in this regard. They supervised the preparation of a readily available cardiac resuscitation kit. The surgical nurses were instructed so that they would be better able to assist in this emergency. Special placards entitled "Program of Action—Cardiac Arrest" were conspicuously placed in each scrub room and operating room so that all concerned would have the opportunity to review the significant steps frequently and thus become more familiar with them.

In July, 1954, through the combined efforts of the Los Angeles County Heart Association and the University of Southern California School of Medicine, a practical course in cardiac resuscitation was established. This course has been made available to all resident physicians as well as to all private practitioners in the area. Many surgical nurses and supervisors have participated in the course, which is conducted one evening each week and consists of a two-hour session during which the practical aspects of cardiac resuscitation are first discussed and then applied on anesthetized dogs. The students are afforded the opportunity of performing a thoracotomy and resuscitating cardiac arrest due to both ventricular standstill and ventricular fibrillation. They receive instruction in the use of indicated drugs and in the technic of defibrillation.

Noteworthy has been the observation that few physicians are able to produce effective cardiac massage on their first trial. Before completing the course, each physician is required to be able to produce consistently a palpable peripheral pulse and maintain a mean arterial blood pressure of at least 40 mm. of Hg.

The concept is growing that all surgeons, regardless of training or specialty, should be adept in performing a thoracotomy and well oriented in the technic of cardiac resuscitation. With the exception of those surgeons routinely performing cardiac or thoracic surgery, the catastrophe of cardiac arrest usually is presented to a surgeon who has little knowledge of the intrathoracic cavity. He is expected, within a few moments, to confirm the diagnosis, perform a thoracotomy, and institute effective cardiac compression.

The decision to initiate and carry out the procedure of cardiac resuscitation is a great responsibility. In any field of surgery, a responsibility of similar magnitude would require carefully supervised training. It is a fallacy to assume that similar training is not required to develop proficiency in cardiac resuscitation. Every operating surgeon can no longer avoid his responsibility in securing such adequate preparation. Furthermore, attending lectures and reading articles on cardiac arrest, though valuable, do not provide sufficient preparation.

The validity of these foregoing opinions has been supported by the evidence accumulated during the past few years. A significant improvement in the ability of the resident surgeons at the Los Angeles County Hospital to resuscitate their patients has taken place since the introduction of the course described above. This improvement is apparent in an analysis of cardiac arrest at this hospital during the past two years, the period immediately following the previous four-year study.

From January, 1955 to January 1957, 33 instances of cardiac arrest occurred in the operating rooms of this hospital. These 33 cases may be separated into two groups. The first group of 14 patients are those in whom cardiac resuscitation was attempted by a surgeon who had not had the benefit of the practical train-

(Continued on next page)

ing course described above. Of these, but three patients were successfully resuscitated, resulting in a rate of successful resuscitation of 21 percent. This figure compares directly with the figure for the previous four years in which 17 of 82 patients, or 20 percent, were resuscitated.

In the second group of 19 patients, cardiac resuscitation was attempted by a surgeon who had participated in the practical training course. Of these, 15 patients, or 79 percent, were successfully resuscitated. The impression is inescapable that practical training in cardiac resuscitation has provided the basis for this marked improvement in salvage of these patients.

STEPS IN TREATMENT

When cardiac arrest is suspected because of the anesthesiologist's inability to palpate a peripheral pulse or obtain a systolic blood pressure, the surgeon palpates the femoral vessels. If an abdominal incision has been made, the aorta or the heart is palpated through the diaphragm. If a palpable pulse is not obtained, the diagnosis of cardiac arrest is confirmed.

We caution against using the stethoscope to listen for heart sounds, waiting for an electrocardiogram, or readjusting the sphygmomanometer cuff. These maneuvers are of little value and waste time when even seconds are important. Although experimentally the cerebrum can tolerate cessation of oxygenation for three to four minutes, the situation is not always comparable clinically.

The surgeon calls for the cardiac resuscitation kit. The anesthesiologist ventilates the lungs with 100 percent oxygen. An endotracheal tube, if not already in position, is inserted as soon as it is practical. The patient is placed in the Trendelenburg position. Mouth-to-mouth breathing can be maintained for a short time if an anesthesiologist is not immediately available.

If the abdomen has been opened, the surgeon repeatedly compresses the heart against the posterior aspect of the sternum through the intact diaphragm. If ineffective, cardiac massage done in this manner should be continued for no longer than 10 seconds. If effective, the resuscitation has probably been due to mechanical myocardial stimulation.

Effective circulation can be produced only by manual compression of the heart through the open chest. Direct visualization and palpation of the heart are required for satisfactory drug injections. This is necessary to insure the proper site of injection as well as to avoid injury to the coronary vessels. We do not recommend incision of the diaphragm.

The surgeon opens the left chest through an incision extending from approximately the lateral sternal border to the mid-axillary line below the left breast. Usual asepsis is not followed. No effort is made to count the interspaces. After the intercostal incision has been made, it is helpful if the costal cartilages above and below the incised interspace are cut across adjacent to the sternum. This allows for easier introduction of the hand into the chest. A rib spreader will improve the exposure. The heart is then compressed against the posterior aspect of the sternum for five or six vigorous thrusts.

If this maneuver is ineffective in restoring spontaneous heart action, cardiac massage is then instituted with one or both hands, using sufficiently forceful compression so that an assistant is able to palpate a peripheral pulse. Incising the pericardium may be required. If a peripheral pulse cannot be palpated, the character of the cardiac massage is considered unsatisfactory.

Once effective massage is attained, it is continued for two to three minutes in order to reoxygenate the cerebrum and myocardium. The rate of cardiac compression should be 60 to 100 per minute.

If spontaneous heart action does not take place by this procedure alone, drug treatment is required. Epinephrine, calcium chloride, and procaine solutions are kept ready for immediate use in vials of 50 cc. in the cardiac resuscitation kit. Each is so prepared that the therapeutic dose is 10 cc. Thus the surgeon, regardless of the drug which he wishes to use, needs to remember only that 10 cc. of the prepared solution contains the correct amount of drug and the bottle is so labeled.

The program to be instituted from this point will depend upon whether the cardiac arrest is due to ventricular standstill or ventricular fibrillation. For ventricular standstill, which comprises about 85 to 90 percent of these catastrophes, the following program is instituted:

0.3 cc. of 1:1000 dilution of epinephrine (10 cc. of the prepared solution) is injected directly into the chamber of the left or right ventricle. Cardiac massage is interrupted for only as long as it is required to complete the injection. Massage is then resumed, and if after two or three minutes only feeble ventricular contractions occur, 3 cc. of 10 percent solution of calcium chloride (diluted to 10 cc.) is injected and massage is continued. As long as the ventricular contractions are by themselves ineffectual, the surgeon will find no difficulty in massaging the heart. As soon as the ventricular contractions become forceful, he will find it impossible to continue to assist the heart, and thus easily recognize that further massage is not required.

If there is no ventricular response to the first injection of epinephrine, a second dose is given. If there is still no ventricular response, we administer calcium chloride. Massage is continued throughout. If there is no response after two injections of calcium chloride, it is probably futile to continue efforts of resuscitation. However, if but a feeble ventricular response occurs, efforts at resuscitation must be continued indefinitely. At the present time there are no other drugs that we recommend, although isopropyl norepinephrine, atropine, and others have been advocated.

DEFIBRILLATION

For ventricular fibrillation, after the initial period of cardiac massage of approximately two minutes, defibrillation is attempted by momentary electric shock, with the duration of pulse set at 0.1 second and the voltage set at least at 135 volts. The electrodes are placed so that as much myocardium as possible is encompassed between them. If the defibrillation is successful, ventricular standstill will be produced.

The period of standstill may be temporary or prolonged. If prolonged, it must be treated in the same manner as described for standstill, with the exception that epinephrine is used only as a last resort because of its potent fibrillatory effect.

If the initial electric shock was ineffective, a second

electric shock is applied. If this as well is ineffective, a series of five or six shocks is given in rapid succession. If this is still ineffective, 10 cc. of 1 percent procaine is injected into the chamber of the left or right ventricle. Massage is continued for a minute or so and the electric shock is repeated.

Our experience in the dog laboratory has demonstrated the effectiveness of procaine in aiding defibrillation. The resulting standstill, however, is sometimes very difficult to resuscitate because of the marked myocardial depressant action of the procaine. Consequently, we advise efforts at defibrillation with electric shock alone before using procaine.

After successful resuscitation the pericardium is partially closed if previously opened. The pleural space is cleansed with saline solution, topical antibiotics are instilled, intercostal tube drainage is established, and the chest is closed in routine fashion.

The Nurse's Responsibility in Cardiac Arrest

By Gloria Castillo, R.N.*

• When the doctor says, "It's cardiac arrest," what does the nurse do? Is she thrown into a moment of panic or does she slip into her role as a member of the team?

As more is learned about cardiac arrest, the more it is realized that the participation of the nurse as a member of the team may determine whether the patient lives, dies, or exists as a vegetable. When a patient's heart unexpectedly stops beating, it is mandatory that a trained team consisting of the surgeons, the anesthetist, and the nurses carry out a definite plan to reestablish the patient's oxygen supply and restore his heart beat.

Cardiac arrest is not as rare as has been believed. It is estimated that in the operating rooms in this country between 12 to 60 persons are killed yearly by static electric sparks.[1] Compare these figures with those given by Dr. Mikkelsen for cardiac arrest occurring in just one hospital. Thus it would seem that safety measures and programs for combatting cardiac arrest should be as vital as safety measures and programs for preventing explosion hazards.

Preparedness hinges upon the organization of the operating room and all its personnel. A hospital should establish a recognized program for cardiac arrest that should be known by all members of the operating room team.

The equipment should be easily accessible and ready for use at all times. This is the responsibility of the nurse. Because every second is vital, the location of the equipment must be known. Valuable time must not be wasted looking for it. Such a delay could easily determine the success or failure of the resuscitation.

Every operating room suite should be equipped with a cardiac arrest cart that is compact, complete, and ready for use whenever an emergency occurs. The cart should be well labeled. It could be painted red to make it especially conspicuous, and should be small enough in size to be easily moved.

It is very important that the cart be centrally located and easily accessible to all the operating rooms. The hall may be the best location. The cart should be mobile for rapid wheeling into the area in which it is needed, and should be equipped with a railing or some type of siding, so that the equipment will not slide off as it is being rushed to the site of the emergency.

This cart should meet the needs of each individual hospital, and should accommodate all the supplies and equipment needed. This equipment should consist of instruments, syringes, medications, and the defibrillator.

It is very important that the doctor be able to reach for the knife without wasting valuable seconds plowing through a pile of instruments. Those really needed are: the knife handle with knife blade attached (preferably two), a pair of Metzenbaum scissors or long scissors, a long tissue forceps, a rib retractor, and two or three 10 cc. syringes with No. 21 needles about 1½" long attached. Saline is advised to wet the electrodes for better contact.

Each individual hospital situation would determine the need for extra instruments. If the cart is to be used elsewhere in the hospital—for example, in the tonsil, genitourinary, x-ray, and bronchoscopy rooms—it would be advisable to add the instruments necessary for closure of the chest. If the tray is used only in the major operating room suite, there is sufficient time during the observation period following resuscitation to get these extra supplies.

(According to an article in the January 15, 1957 issue of the *Canadian Medical Journal*, one of every six cases of cardiac arrest occurs outside the operating room. The author therefore suggests that two cardiac arrest trays be available.—ED.)

If a hospital has only one rib retractor, this instrument can be wrapped separately and kept sterile on the cardiac arrest cart, and still be available for elective operations as needed.

(Other instruments can be used by the physician to hold the chest open. Therefore if the hospital has only one rib retractor, it might be well to substitute some other instrument for the retractor on the cardiac arrest tray.—ED.)

In one hospital in which it was not standard practice to include the knife blades on the resuscitation tray, a nurse timed herself one day and discovered that five seconds were required to get the blades out of solution and onto the knife handle. This does not seem long, but when every second is vital it is well to have the knife handle and blade assembled before sterilization of the tray. If the tray is allowed to dry thoroughly in a hot chamber before being removed from the sterilizer, corrosion is no problem.

(Also, stainless steel blades are available which will withstand repeated exposure to steam sterilization without any corrosion.—ED.)

Trays should be checked at least once a month.

Selection of the drugs to be included on the cardiac arrest cart will be made by the attending staff. The

(Continued on next page)

*Miss Castillo, who was on the operating room staff of the Centinela Valley Hospital, Inglewood, Calif., when this paper was prepared, is now assistant surgical supervisor at the Methodist Hospital of Southern California, Arcadia, Calif.

dosage of these drugs must be standardized. There is not sufficient time to use Young's rule to figure out the correct dosage. It is suggested that all the drugs be diluted so that the required dose of any of them will be contained in a 10 cc. dose.

At the University of Southern California it is believed that three drugs are sufficient. These are epinephrine 1:30,000, calcium chloride 3%, and procaine 1%. In this dilution the correct dosage is 10 cc. Bottles of 50 cc. or 10 cc. of these drugs can be made up and should be labeled with this information.

USE OF DEFIBRILLATOR

While the defibrillator is an instrument that will be used only by the doctor, the nurse should be well acquainted with the technic of its use and its inherent dangers to the operating room personnel. The nurse, as well as the doctor, should be familiar with the voltage and duration of the electric shock required to defibrillate. This may mean the difference between a burn of the myocardium and a successful resuscitation.

It has been ascertained in the experimental laboratory at the University of Southern California that the most effective time duration for the application of the shock is 0.1 of a second. This short time interval also minimizes the potential for myocardial burning.

There are variations in voltage supplied to the operating rooms, with the various lines identified by different wall plugs. The nurse should check with the hospital engineer if she has any questions regarding identification of the plugs.

ELECTRODES

Electrodes that have a concave surface are superior to those with a flat surface, because they fit around the heart better and make full contact. These concave electrodes may be purchased in the near future.

Since the electrodes should be maintained sterile, the nurse should know whether the type the hospital has will tolerate autoclaving. Although it is usually impossible to maintain strict aseptic technic in cardiac arrest, wound contamination is minimized by the use of sterile equipment. Most defibrillator electrodes now available will withstand autoclaving. However, this equipment is subject to deterioration after frequent autoclaving.

Several hospitals in the Los Angeles area have homemade defibrillators, which may not have circuit-breakers to control overloading of the circuit. If the defibrillator does not have a circuit-breaker, an adequate supply of reserve fuses must be available. The location of the fuse and the manner in which it should be changed should be known by the nurse, since it will probably be her duty to change it. This information may be obtained from the hospital engineer or the person who constructed the equipment.

DANGERS TO PERSONNEL

The dangers inherent in the use of the defibrillator must be appreciated by all operating room personnel. Contact of both electrode surfaces to any part of the body (of a staff member) during application of the current may produce electrocution. Close approximation of the electrode surfaces to each other may produce an arc with the danger of explosion of anesthetic gases.

As a result of the electric shock, there is a tonic spasm of the whole body of the patient. Manual restraint during the application of electric shock by other members of the operating room team may safely be done without danger of electrocution, since the current passes directly between the two electrodes only.

The nurse should be familiar with her defibrillator, and make sure it is always complete and in good working condition. Most defibrillators are equipped with visible signals to indicate when the unit is not functioning properly. The nurse should not be afraid of the defibrillator. The manufacturer or his local representative will be glad to demonstrate its use and answer any questions.

The nurse can be of further assistance by switching on the wall stop clock so that the doctors will have an accurate knowledge of the time elapsing before cardiac resuscitation has been completed. During the cardiac massage, the nurse can ascertain the pulse, and inform the doctor of the adequacy of his massage.

Cardiac arrest is an ever-present hazard in the operating room. "It can never happen to me" is a human reaction, but one that must be overcome. It is too late to organize for therapy once cardiac arrest has occurred.

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Cardiac Arrest

Brown, R. Cecil: "Hyperpyrexia and Anesthesia." *Brit. M. J. 2:1526; Dec. 25, '54.*

Forty minutes after induction of anesthesia (sodium thiopentone, nitrous oxide, oxygen, and trichlorethylene) a normal 13-year-old girl developed clonic convulsions, respiratory distress, and cyanosis. Anesthesia was discontinued, and the child's temperature was taken by axilla. It was 108.6° F. on first examination and 110° F. on second. Resuscitative measures failed, and the child died.

Her preoperative physical examination had been negative except for the minor orthopedic difficulty which was being corrected at the time of the fatality. Preoperative medication had included 1/8 gr. of morphia and 1/100 gr. of atropine. Necropsy findings were essentially negative.

When possible causes for death had been ruled out by laboratory test and analysis, attention was turned to the possible contribution of the environment. The operating room was itself air-conditioned, but two adjoining anesthetizing rooms were not, and temperature readings in the room which had housed the patient ran as high as 85° F. under conditions approximating those of the day the patient had died. The temperature of the operating room on this same day was 79° F., and the temperature under the drape sheet covering a patient, 87° F.

The deceased patient had waited for 1.5 hours in the anesthetizing room at the hottest time of day. The author points out that while temperatures in this room did not exceed the thermal tolerability of an adult, they may have exceeded those of a child.

It is surmised that the patient's temperature started to rise while she was waiting in the hot

sun and continued to rise in the operating room when sheets and drapes were applied. The author warns that the patient's temperature under drapes may exceed considerably that of the room.

No attempt is made to correlate the relationship of hyperpyrexia and convulsions.

Lynch, Robert: "Analysis of 119 Hospital Deaths on a Surgical Service." *Ann. Surg. 143:855; June '56.*

In an analysis of 119 deaths occurring in 3,314 patients on a surgical service over a three-year period, it appears that pulmonary complications are the primary cause of death. Forty-nine deaths could be attributed to this cause, with 26 of the cases pulmonary embolus or infarction. Five cases of cardiac arrest occurred in a series of 4,375 surgical cases, four being treated with cardiac massage without success.

Hingson, R. A., Holden, W. D., and Barnes, A. C.: "Mechanisms Involved in Anesthetic Deaths." *N. Y. St. J. Med. 56:230; Jan. 15, '56.*

For the period covering 1945 to 1954, 127 operating room deaths in 136,043 anesthesias are analyzed. Ninety-seven were autopsied. Thirty-two could be attributed to cardiac arrest, 12 to aspiration, 10 to hemorrhage, nine to respiratory arrest, nine to vascular occlusion during surgery, nine to toxic or traumatic shock without major hemorrhage, eight to intracranial hemorrhage, eight to asphyxia and airway obstruction, and 30 to unclassified and miscellaneous reasons, including rare and indeterminate causes.

Six of this latter group were fatalities occurring during the injection of radiopaque drugs or endoscopy for diagnosis.

Although it is improper to lay the cause of death to any one standard agent or technic, the authors think unnecessary anesthesia failures can be reduced with a program to include more thorough training for anesthetics and closer teamwork between surgeon, obstetrician, and anesthetist. Life-saving resuscitative equipment needs improvement, and operating tables which will allow prompt Trendelenburg position are needed. Prophylactic intravenous fluids and blood should be given during major surgery.

An anesthesia staff sufficient to provide 24-hour coverage is essential, as is a well-staffed, equipped, and located postanesthesia room.

The report includes a detailed analysis of deaths in relation to anesthetic used; patient age groups; curare and various anesthetic agents.

Fish, D., Boyle, J., Hochhauser, M., and Wood, S. W.: "The Routine Use of Amplified Heart Sounds During Surgery." *Ann. Surg. 144:1013; Dec. '56.*

Believing that a big point in delay in treatment of cardiac arrest is the interval between the time of cardiac arrest and the time of discovery, the authors reasoned that routine broadcasting of the surgical patient's heart beat would be useful in alerting the anesthetist and surgeon to changes in the patient's condition.

The equipment designed consists of an ordinary diaphragm-type stethoscope connected to a pencil microphone, connected in turn by a long, flexible cable to a pre-amplifier located outside the operating room. At this point, the pre-amplifier is connected to a power amplifier from which a cable runs back into the operating room to a speaker located near the ceiling.

All precautions to avoid explosion hazards are observed. The stethoscope head is loosely taped to the patient's chest at the point of maximum impulse and the volume adjusted.

The apparatus is no more complicated than the ordinary blood-pressure apparatus, and the authors feel that even with certain minor disadvantages, it offers additional safety for the surgical patient.

They cite the incident of a rapid increase in heart rate following traction on the small bowel during an exploratory laparotomy. The rate returned to normal immediately after the traction was released. Very gentle traction caused the same increase in heart beat with a drop in blood pressure.

The same maneuver tried on subsequent patients caused no variation in heart beat, and it is the opinion of the authors that the first patient had a sensitivity to the reflex stimulus which was detected before a significant drop in blood pressure could occur.

Cronkite, Alfred E.: "Necropsy Findings in Patients Dying on the Operating Room Table." *Anes. & Analg. 36:19; Jan.-Feb. '57.*

In a review of literature dealng with patient death on the operating table, the author found that adequate anatomic cause was not disclosed in the majority of cases. The most frequently occurring anatomic cause demonstrated was unrecognized cardiac infarcts. In the author's own series of nine cases, autopsy revealed anatomic cause in only four cases. Of the remaining five, no demonstrable cause was found.

The following articles outline etiology, prevention and treatment with cardiac massage, drugs, artificial pacemakers, defibrillators, etc. In each the necessity for anticipating the occurrence is stressed, and suggestions for corrective facilities are outlined.

Bigelow, W. G., Heimbecker, R. O., and Trusler, G.: "The Practical Management of Cardiac Arrest." *Canad. M. A. J. 76:86; Jan. '57.*

Wylie, W. D.: "The Treatment of Cardiac Arrest." *Brit. J. Anaesth. 28:551; Dec. '56.*

Robinson, C. L.: "Cardiac Resuscitation in Surgery." *Canad. M. Ass. J. 75:651; Oct. '56.*

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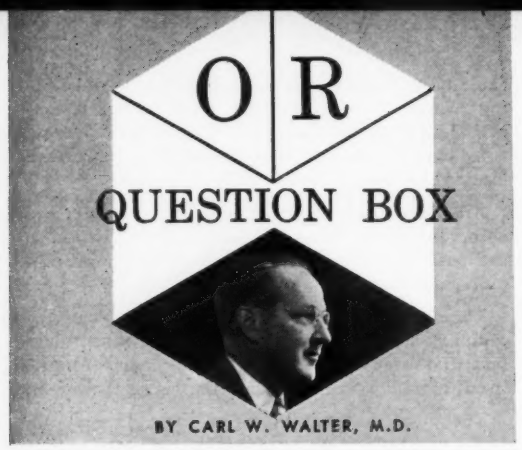
O'Reilly, K. S., and Ohlke, R. F.: "Cardiac Arrest: Causation and Management." *Canad. M. Ass. J. 75:202; Aug. '56.*

Hewlett, T. H., Gilpatrick, C. W., and Bowers, W. F.: "Cardiac Arrest." *Surg. Gynec. & Obst. 102:607; May '56.*

Yasui, R. S.: "Cardiac Arrest." *Med. Bull. U.S. Army, Europe 13:180; Aug. '56.*



Assisted by Dorothy W. Errera, R.N.

Q. How would you suggest eliminating so much talking and motion in an operating room in a teaching institution, especially when there may be as many as 15 or 20 persons in the room?

A. The ultimate care and safety of the patient remain the responsibility of the surgeon. If he has been educated to the likelihood of wound sepsis from airborne bacteria freed from the nasopharynx or stirred up from a dirty floor and he refuses to take the initiative in eliminating unseemly operating room behavior, the supervisor has no choice but to make the environment as safe as possible — by disinfecting the floor daily, providing good masks, providing clean, lint-free, cotton clothing for visitors, and eliciting the cooperation of the administration in enforcing standards of safety from explosion hazards by insisting on conductive footwear for all who enter the operating area.

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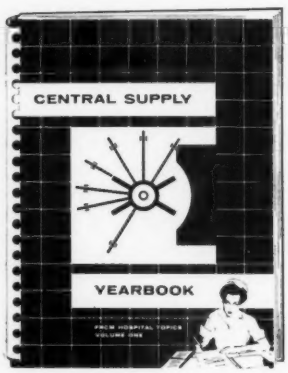

HOSPITAL TOPICS was the first hospital publication to recognize the importance of the central supply department by establishing a special section for its personnel. From those articles the editors have carefully selected the ones which appear in this yearbook. They deal with every major CSR problem, whether it's methods of sterilization, inservice training, or work simplification. Among the authors: Margaret K. Schafer, R.N., Frederick Markus and Jean Christie, R.N., Velma Chandler, Ph.D., Betsey Carroll, R.N.

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Q. How often must commercially sterile sponges be resterilized to make sure that they are safe for operating room use?

A. Commercial packaging and sterilizing practices are such that sterile paper-packaged dressings can be stored indefinitely without resterilization. The packages should be inspected before use to make certain that the wrappers are intact.

During storage care must be taken to keep vermin away from the packages, since their excreta are often moist enough to penetrate and contaminate the contents. Similarly, the paper-wrapped packages must be protected from moisture of any kind that might contaminate the contents.

Q. Do you feel it is good technic, organization of work, and management to set up tables for the entire day as far as instruments will go? Are these tables sufficiently covered with long double-thickness drapes? I don't dare ask you if you approve of lifting drapes carefully in order to obtain a sterile instrument in a hurry.

A. The use of common supply tables for sterile equipment is an obsolete technic which should be abandoned. No matter how much you drape them, they are susceptible to contamination by curious people, insects, poor transfer technics, and harried personnel. Every patient deserves an individually wrapped and sterilized kit of dry goods and a separately sterilized kit of instruments.

When such kits are organized and arranged as outlined in Chapters 10, 11, and 14 of *Aseptic Treatment of Wounds*, the entire preoperative setup is a matter of five minutes.

Q. Is distilled water sterile right after it is distilled? If so, how long does it remain sterile? Is there a time limit as to when it should be used?

A. For safe parenteral injection, distilled water should be sterilized immediately after distillation. Contamination of distilled water can be by many routes, including still design. Chemically pure distilled water can be stored only if it is hermetically sealed in sterile containers.

The storage tank of any still should be of a size to accommodate only enough distilled water for a working supply. Storage tanks must be drained dry after use to keep bacteria from growing in residual water.

Q. In using the steam sterilizer for dry heat, should the material be placed on the floor of the autoclave or on trays?

A. Material may be placed anywhere in the sterilizer.

Q. When sterilizing eye instruments in dry heat in aluminum foil, should they be wrapped in the foil or placed on a tray lined with foil?

A. Either technic is satisfactory, although there is no advantage to lining a tray with foil. Wrapping the instruments in aluminum foil facilitates transportation of the instrument from the sterilizer to the operating room or provides a suitable container for storing the sterile instruments.

Q. In biopsying a breast tumor or operating on a malignancy, should new instruments be used throughout the operation?

A. There is recognized evidence that tumor cells can be implanted by soiled instruments. No instruments used in a case of malignancy or suspected malignancy should be returned to the field without resterilization.

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(Continued from page 53)

injection of an infected needle, when the nurse failed to follow the standard hospital procedure of sterilizing the hypodermic needle.

For illustration, in Kalmus v. Cedars of Lebanon Hospital, 281 Pac. (2d) 872, the testimony showed that Kalmus entered the Cedars of Lebanon Hospital for observation and diagnosis. Her physical examination was negative on admission. The record of her case contains no indication of any infection prior to that time. Her regular physician testified that she had had no previous abscesses or blood disorder.

The next day at about 10 p.m. she was given an injection to relax her nerves. Soon after the injection in Kalmus' thigh, the area began to hurt and sting, began to swell, and by morning was badly swollen and red. The laboratory report said the culture showed a staphylococcus aureus hemolytic, a common organism often found upon a patient's skin.

Testimony showed that the nurse had used an infected needle, and had failed to follow standard hospital procedure. In holding the Cedars of Lebanon Hospital liable in $3,000 damages to Kalmus, the higher court said:

"Standard practice requires not only that the instrument be sterilized but also that the skin be scrubbed with an alcohol sponge. Plaintiff's (Kalmus') testimony warrants the inference that this was not done. And the only conclusion flowing from Dr. Mand's testimony is that the abscess was caused by use of an infected needle."

The higher court refused to hold that the hospital could collect Kalmus' hospital bill of $513.29, and said:

"Mrs. Kalmus' hospitalization was proximately caused by defendant's (hospital's) negligence. It would be a new and surprising doctrine that would enable the tort-feasor to recover from the injured party a part of the cost of curing his injuries. Had plaintiff (Kalmus) gone to another hospital while being treated for the effects of defendant's negligence, that expense would be recoverable from defendant in addition to the $3,000 awarded by the court."

Examining an operating table in the Federal Civil Defense Administration's Emergency Hospital, Battle Creek, Mich. are (l. to r.): John T. Goltman, FCDA hospital coordinator; Margaret Schafer, chief nurse; George E. Patterson, Bergen County (N. J.) director of administration for health services, and Carlisle S. Lentz, M.D., hospital consultant. Mr. Patterson was attending a special health services course detailing areas of cooperation and responsibility between the medical profession and civil defense.

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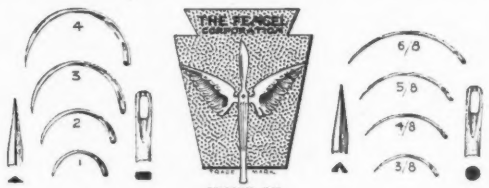

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The Book Corner

Tell Patient Truth?

SHOULD THE PATIENT KNOW THE TRUTH? Edited by Samuel Standard, M.D., and Helmuth Nathan, M.D. New York: Springer Publishing Co. 1955. 160 pp. Hard cover $3, flexible $2.

Twenty-three contributors — physicians, nurses, theologians, lawyers, an educator, and an administrator—give their views on whether a patient should be told of existing mental illness, incurable disease such as cancer, stillbirth, or mongolism, and other upsetting conditions.

Some believe the patient should be told a degree of the truth, and the family the whole truth. Sometimes, the authors point out, telling the patient cannot be avoided, as in childbirth, but the husband's permission is first obtained.

Viewpoint of the patient is also discussed. His personality and willingness to know the truth are considerations.

Medical and moral ethics, religious beliefs, and even legal aspects enter the picture. For example, the patient may need to be made aware of the necessity for making a will.

Diseases considered incurable today may be curable tomorrow, it is pointed out, and thus what appears to be a hopeless outlook may not always be so.

Microbiology for Nurses

MICROBIOLOGY WITH APPLICATIONS TO NURSING. Catherine Jones Witton, M.A. New York: The Blakiston Division, McGraw-Hill Book Co., Inc. 1956. Second edition. 628 pages. $6.

This comprehensive textbook on a complex subject limits its discussion of microorganisms to those of practical importance to nurses — worms and protozoa, yeasts, molds, bacteria and ultramicroscopic forms — rickettsiae and filtrable viruses.

Its sections are on the basic structure and activities of microorganisms, the control of microorganisms, sources and modes of infection, infection and immunity, introduction to the study of pathogens, the pathogenic bacteria and pathogenic organisms other than bacteria.

The book is well illustrated with photographs, electron micrographs and diagrams. More than a quarter of the illustrations are new.

More material on laboratory methods has been added in this edition, and the sections on bacterial genetics, antigens and antibodies, poliomyelitis and toxoplasmosis have been radically revised.

Discussions of Coxsackie viruses and blastomycosis have been added to this new edition.

Radiological Units Report

A report recently issued by the International Commission on Radiological Units and Measurements covers recommendations agreed upon at its meetings in Geneva, April, 1956, and replaces the commission's earlier report issued in 1953.

The handbook, divided into four chapters, discusses radiological quantities, units, and symbols; clinical application of absorbed dose measurements, with examples; treatment of the physical aspects of absorbed dose determination; and a discussion of reports of the subcommittees, primary standards, x-ray standards, and radioactivity standards in various countries and laboratories, as well as extensive bibliography.

The 38 page report (National Bureau of Standards Handbook 62) is available for 40 cents from the U.S. Government Printing Office.

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1. Zintel, H. A.: *Surg. Clin. North America,* 36:257, Apr., 1956. 2. Freeman, B. S.; and Young, T. K., Jr.: *Arch. Surg.,* 61:1145, Dec., 1950.

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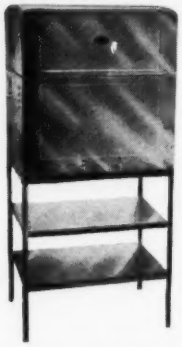

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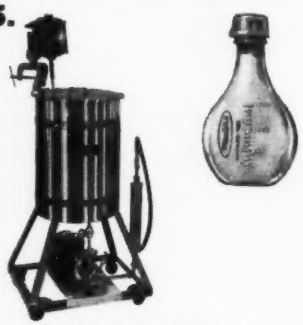

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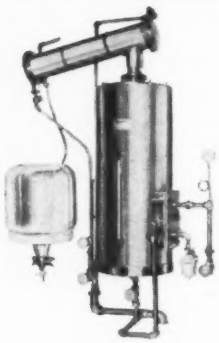

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Training Technics Discussed At Tri-State CSR Sessions

Central Supply

Sessions for central supply department personnel were held again this year at the Tri-State Hospital Assembly in Chicago. Abstracts of papers follow.

Fulfilling Basic Desires Helps in Motivation

Tell Employees Why You Want Them to Learn

Good training does not in itself make for good employees. Proper motivation is also needed. What motivates employees? There are several basic desires to be fulfilled:

(1) Desire to belong. It is hard to develop a feeling of belonging — of identification with the hospital and with a specific department—in persons who are scattered throughout the hospital (housekeeping employees, for instance). Since central service personnel tend to remain in one area, it should be much easier to fulfill the desire to belong.

(2) Desire for recognition—to be known and liked as an individual. It is difficult for central service to fulfill this need, because any feelings of prestige which nonprofessional employees may develop are often cut down unwittingly by persons with "built-in prestige" (professional persons).

(3) Desire for security. Hospitals have quite a bit of job security in comparison with industry, but even with job security there can be much insecurity — from constant changes without explanation, lack of human treatment by those in authority, or poor coordination, for example.

(4) Desire for new experience. Many hospital jobs have a great deal of variety, but because of the many repetitive jobs in the central service department, it may be difficult to fulfill this desire.

When these basic desires are not fulfilled, the results are lonelilness and neglect, insecurity and boredom.

There are basic laws of learning which must be taken into consideration, or the best training technics will be meaningless. These laws are:

(1) Learning must be motivated. People are not naturally inclined to learn. You must show them the rewards, and let them know why you want them to do what you want them to do. Then praise them for their successes.

(2) Persons undergoing a learning situation respond best to things that are meaningful to them. Go from the known to the unknown — again, tell why.

(3) A person learns best when he is ready to learn. Remember that he cannot concentrate on more than one thing at a time.

(4) Learning involves activities—physical as well as mental.

(5) Repetition is essential.—**Russell McBride,** Training Specialist, Johnson & Johnson, New Brunswick, N.J.

Speakers at one session were (l. to r.): William D. M. Snell, assistant chief engineer, Henrotin Hospital, Chicago; T. N. Silzer, personnel director, Johnson & Johnson, Chicago; and Russell McBride, training specialist, Johnson & Johnson, New Brunswick, N.J.

85% of New Items From Hospital People

Describes Steps in Evolution of Product

Eighty-five percent of all new items added to a hospital line come from persons directly connected with hospitals. Ideas for products are welcomed.

There are eight steps in the evolution of a new product:

(1) Statement of the problem—including a definition of what is wanted, a description of present methods of doing the job and of methods which have been discarded, and a list of characteristics the new system must have.

(2) Suggested means of solution. This may come from constructive new thinking on the part of one person, the inventor; from the various suggestions of a group of persons participating in a brainstorming session, or from outside experts. Or the suggested solution may be an adaptation

(Continued on next page)

At the Tri-State Hospital Assembly

●

Encouraging reports at this Chicago meeting were received from the many nurses who stopped at the Diack booth.

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of presently used ideas or systems from another field.

(3) Combination and modification of suggestions to arrive at a new item.

(4) Market survey — to determine the market potential and the ability of the product to do the job.

(5) Redesigning for production. This is an essential and expensive step.

(6) Manufacture.

(7) Distribution. Among factors to consider are packing, stocking, handling, and shipping. If a distributor is to take on a new item, there must be enough margin to carry this overhead expense.

(8) Promotion, including literature, bulletin advertising, advertising in periodicals, technical explanations, commissions to salesmen, and samples. —**Basil Burrell**, Research Engineer, American Hospital Supply Corp., Evanston, Ill.

Administrator Tells What He Expects of CSR

Warns of Quick Changes With Little Preparation

Some desirable goals which can be achieved through a properly functioning central service department are: better standardization of materials; good maintenance and control of equipment; a smaller over-all inventory, and economy of time, energy and motion.

To accomplish a smooth-functioning department, we need adequate space if possible. We need constant study and use of methods improvement techniques, and an awareness of the needs of the nursing units and a real appreciation of their problems.

We need a supervisor for the department who is willing to investigate and change, and is constantly evaluating the products used.

We need and expect economy — in operation and in use of supplies. We need a standard, simple manual that will inform all those in the hospital who are concerned what this department is supposed to do.

No changes should be made in our by central service without prior consultation with everyone concerned. Any proposals for controls or changes should be well explained in advance and carefully documented.

We need the confidence of everybody in the hospital in this department. The supervisor must realize that her responsibility is to give service, and she may have to "sell" other departments on her service.

I believe in complete central service, not just controlled service. However, acceptance by other services in the

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ospital then presupposes adequate ervices.

To broaden its usefulness, the department should be responsible for ll miscellaneous equipment that is tored, unless there is some specific eason for putting it in another department. There is some trend toward acceptance of this concept. Of ourse, adequate space is essential. I hink all planning should allow for pace for such storage.—**Leonard P. Goudy**, Administrator, Proctor Community Hospital, Peoria, Ill.

Foundation Orders X-ray Generators for Cancer

Twelve 2,000,000-volt x-ray generators for treatment of deep-seated cancers have been ordered by the Donner Foundation of Philadelphia, at a cost of $822,000.

Robert A. Maes, executive vice-president of the charitable foundation, said the machines would be installed before the end of the year in the following medical and radiological centers:

The Los Angeles Tumor Institute; Johns Hopkins University Hospital, Baltimore; Charity Hospital of Louisiana, New Orleans; department of radiology, University of Pennsylvania Hospital, and Temple University Hospital, Philadelphia; University of Oregon, Portland, and the division of radiotherapy and isotopes, Mary Fletcher Hospital, Burlington, Vt.

The Tom B. Bond Radiological Group, Ft. Worth, Tex.; department of radiotherapy, St. Joseph Infirmary, Louisville, Ky.; University of Missouri School of Medicine, Columbia; University Hospital, Oklahoma City, and Grace-New Haven Community Hospital, New Haven, Conn.

Room Rates in General Hospitals Show Increase in Past Year

Room rates in United States general hospitals have risen about six percent in the past year, reports the American Hospital Association.

Average rate for single rooms was $15.19, up 7.4 percent from $14.14 in 1955; for two-bed rooms, $12.16, up 5.6 percent from $11.51, and for multibed rooms, $10.58, up 5.8 percent from $9.84 a year ago.

The results were based on 2,835 completed questionnaires from short-term hospitals in the United States and Canada.

The highest averages by region were from the Pacific states (Washington, Oregon, California), which showed averages of $20.32 for single rooms, $17.05 for two-bed, and $15.78 for multibed rooms. Lowest average rates were found in the West South Central region (Arkansas, Louisiana, Oklahoma, Texas)—$11.53, $8.96, and $7.49 for single, two-bed and multibed rooms, respectively.

American Chemical Society Makes Achievement Award

Melvin Calvin, Ph.D., has been presented $1000 from Nuclear-Chicago Corp., and a certificate in recognition of special achievement from the American Chemical Society.

Dr. Calvin is director, Bio-Organic Group of the Radiation Laboratory, University of California, Berkeley. The award was established for persons qualifying through "diverse demonstrations of the power of radioisotopes in the field of chemistry."

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[1]Production model of unit described in "CARDIAC MONITOR FOR SURGERY AND RESUSCITATION," *Fields, T., Kaplan, E., Abrams, B., Simpson, R., Gordon, A., and Kenski, J.*, **J.A.M.A.**, *Vol. 162, pp. 595-561*, **October 6, 1956.**

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ASMT to Hold 25th Anniversary Meeting in Chicago

Approximately 2,000 persons are expected to attend the 25th anniversary convention of the American Society of Medical Technologists, at the Palmer House, Chicago, June 23-28.

Feature of the opening session on Monday morning, June 24, will be a symposium on "Uses of Radioactive Isotopes in Medicine and Medical Research." Participants will be:

John A. Cooper, M.D., associate professor of biochemistry and assistant dean, Northwestern University Medical School, Chicago; Y. Thomas Oester, M.D., professor of pharmacology, Stritch School of Medicine, Loyola University, Chicago, and acting director, radioisotope laboratory, Hines (Ill.) Hospital; Clifford Gurney, M.D., and Ernest Beutler, M.D., assistant professors of medicine, and Robert J. Hasterlik, M.D., associate professor of medicine, all from the University of Chicago School of Medicine. Dr. Hasterlik is also associate director, Argonne Cancer Research Hospital, Chicago.

Two other symposiums will be presented—one on mycobacterium, on Monday afternoon, and one on blood-bank technology and immunohematology, on Tuesday morning.

Subjects and speakers in the mycobacterium symposium will be: "Culture Media," Rosemary Colton, B.S., senior bacteriologist, Suburban Cook County Tuberculosis Sanitarium, Hinsdale, Ill.; "Virulence Tests," Yosh Takimura, B.S., senior bacteriologist, Municipal Tuberculosis Sanitarium, Chicago; "Atypical Acid-Fast Bacilli: Emphasis on Non-chromogenic Varieties," Shirley McMillan, M.S., mycologist, Hektoen Institute, Chicago.

"Atypical Acid-Fast Bacilli: Emphasis on the Chromogenic Variety," Ralph Hubble, Ph.D., director of laboratories, Chicago-State Tuberculosis Sanitarium, Chicago; and "BCG Vaccine," Sol R. Rosenthal, M.D., associate professor of preventive medicine, University of Illinois College of Medicine, Chicago.

Discussing advances in blood-bank technology and immunohematology will be Tibor J. Greenwalt, M.D., medical director, Milwaukee (Wis.) Blood Center; James J. Griffitts, M.D., associate director, John Elliott Blood Bank of Dade County, Miami, Fla.; and Kurt Stern, M.D., director, Blood Center, Mount Sinai Medical Research Foundation and Hospital, Chicago.

Among the many other subjects and speakers will be the following:

"Some Legal Pitfalls of a Blood Bank and Its Technologists," George E. Hall, staff associate, law department, American Medical Association, Chicago.

"Micro Determination of Blood pH: Problems and Errors," Samuel Natelson, Ph.D., Rockford (Ill.) Memorial Hospital.

"Detecting Blood Coagulation Defects in the Clinical Laboratory," Mary June Caldwell, B.A., M.T. (ASCP), Henry Ford Hospital, Detroit.

"A Better Understanding of Anion-Cation Balance," Harry F. Weisberg, M.D., assistant professor of clinical medicine, Chicago Medical School.

"The Efficiency and Economy of Routine Micro Methods," Leslie W. Lee, B.S., M.T. (ASCP), Lake View Hospital, Danville, Ill.

"An Immunological Method for Quantitating Serum Gamma Globulin," Patricia Ann Wood, B.A., M.T. (ASCP), University of Washington School of Medicine, Seattle.

"Research Through Time-Lapse Photography," John N. Ott, Jr., Sc.D., Winnetka, Ill.

There will be a conference clinic for supervisors on Wednesday morning, June 26, moderated by Mrs. Selma N. Earle, B.S., M.T. (ASCP), laboratory supervisor, Mount Sinai Hospital, Chicago.

In addition to the formal program of lectures and discussions, there will be study groups and workshops throughout the week. Subjects of study groups will be chemistry, cytology and histology, and tissue culture. The first two (both half-day sessions), will be given three times; the one on tissue culture, an hour-and-a-half session, will be offered twice.

Workshops (on mycology, medical photography, and bone marrow and hematology) will be held away from the Palmer House. The all-day session on bone marrow and hematology is scheduled for Saturday, June 29.

There is a nominal fee for the study groups and workshops. Enrollment is limited, and members and student members will have priority.

Pathologists, Bacteriologists Discuss Environment, Spleen, Cancer

The 54th annual meeting of the American Association of Pathologists and Bacteriologists was held in Washington, D.C., April 8-13. Abstracts of three papers follow.

Cancer Growth Impeded By ThioTEPA Application

Remissions Last from Few Weeks to Six Months

Growth of the tumor was noticeably impeded in more than 50 cases of cancer after application of ThioTEPA.

Not only does this drug appear to have less severe side-effects than some others used in cancer chemotherapy, but it also restrains the growth of more kinds of tumors than other drugs do.

Appreciable inhibition of cancer growth was noted in carcinoma of the ovaries, lung, stomach, liver, mouth, and pancreas, as well as melanomas and lymphomas, including Hodgkin's disease.

(Continued on next page)

Complete remission did not occur in any case studied, but temporary remissions achieved lasted from a few weeks to six months. Tissue study showed noticeable change in the tumor mass, including obvious degeneration and destruction of tumor cells and the formation of fibrous sclerotic tissue in which no tumor cells were evident.

The drug showed marked ability to lessen pain in advanced stages of cancer.

The higher the concentration, the better the effect. Best results were obtained when ThioTEPA was injected directly into the tumor.

Secondary effects appear to be less pronounced than those connected with such drugs as nitrogen mustard, TEPA, TEM, and others.

No patient developed any serious complications in the bone marrow.—**Oscar B. Hunter, Jr., M.D.,** and **C. Barrie Cook, M.D.,** Washington, D.C.

Pathologists Should Study Environmental Causes

Survival Depends on Adapting To New Conditions

The survival of man depends upon his successful adaptation to environmental conditions, which during the last three generations have been revolutionized more completely than during the entire previous period of recorded human existence.

The most important health hazards created by exposure to the new environmental pathogens are related to repeated and prolonged contact to relatively small doses, which do not elicit any dramatic immediate symptoms but produce chronic degenerative diseases sometimes appearing after a long period free from any significant symptomatic reactions.

Pathologists should extend their interest to an increasing degree to the new industry-related environmental causes of diseases, which are bound to occupy in future years a progressively larger share in the general disease panorama.—**W. C. Hueper, M.D.,** National Cancer Institute, Bethesda, Md.

Removal of Spleen May Prolong Life

Transfusion Need Reduced

Removal of the spleen in cases of chronic leukemia and malignant tumors of the lymphatic system can be performed without undue risk and frequently prolongs the life of certain patients.

In a series of patients who had such operations, the need for blood tranfusions was substantially reduced and there was satisfacory and occasional remarkable improvement in many cases. Only two failed to respond in any way.

Only one patient died during the immediate postoperative period, despite the fact that many were in exceedingly poor condition.

There was no evidence that splenectomies increased the susceptibility of patients to infection. On the contrary, certain patients remained free of infection for long periods, probably because of the improved condition of the blood.—**Bong Hak Hyun, M.D., James Butcher, M.D.,** and **R. Phil Custer, M.D.,** Presbyterian Hospital and Graduate School of Medicine, University of Pennsylvania, Philadelphia.

keeping tab on the lab

By Marlene Burgess*

● Every laboratory has its problems, technical and otherwise, from time to time. Frequently outside help is needed to solve them. More often they are solved in the laboratory by the "trial and error" method. The following questions are some which have been asked the author on various problems occurring in laboratories. If you have similar problems, the suggested solutions may help in your case, too.

Q. What are the steps to take if phosphorus determinations are too high to read?

A. Use a smaller amount of filtrate (2 or 3 cc.) and calculate for difference.

Q. What could make the blood urea nitrogen cloudy?

A. It is probably too high and should be set up on a smaller amount of filtrate.

Q. What could make the non-protein nitrogens too high when the standards read the same?

A. It could be the use of an alkaline washing solution for the glassware.

Q. What can be used to keep serum bilirubins from being cloudy?

A. Methyl alcohol instead of ethyl alcohol.

Q. What should one do when the Folin-Wu filtrates filter through cloudy or are discolored in any manner?

A. Discard and make new filtrates. The proportions of acid and sodium tungstate are probably wrong.

Q. If the standard on any test reads differently from previous days, what should be done?

A. All reagents should be checked.

Q. When spinal fluid proteins are too high to read, is it all right to use one-half water and one-half spinal fluid for the determination?

A. Yes, as long as the difference is calculated.

Q. Can hemolyzed serum be used for bilirubin determinations?

A. No, the breakdown of bilirubin obscures end point.

Q. Will the biuret method for performing total proteins be accurate when using jaundiced serum?

A. Probably not.

Q. Should serum which has been standing at room temperature for several hours be used for amylases, acid or alkaline phosphatases?

A. No, because enzymes break down easily if serum has not been frozen.

Q. If a determination reads below 5% or above 90% transmission, will it be accurate?

A. No.

Q. What can be tried to prevent non-protein nitrogens from clouding?

*Laboratory consultant, Division of Hospital Services, Georgia Department of Public Health, Atlanta.

. Adding Nessler's reagent too owly may cause clouding; so add it uickly. The quality of the Nessler's eagent could cause clouding; if so, eplace. Cooling in an ice bath in- ead of at room temperature may revent clouding.

. If a tiny bit of moisture is left in holesterol determinations, will it af- ect results?

. Yes, this will interfere with the olorimetric procedure. Any moisture including any on appartus or pi- ettes) will interfere with color de- elopment.

. If the blood is hemolyzed, can it e used for potassium, BSP, icterus ndex, or phosphorus?

A. Do not use. Recollect.

Q. Where should urine for pregnancy ests be kept until it is mailed, if it as to be sent away?

A. It should be kept in the icebox ntil used. Add 200 mg. of boric acid or each 100 cc. urine when mailing he specimen.

Q. Why does the urine sometimes roduce red color after addition of ferric alum when performing the urine hloride method?

A. Patient has probably been taking alicylates. Repeat test.

Q. When sperm are seen in the rine, should they be reported?

A. Even though not clinically sig- nificant, everything seen in a urine mi- croscopic should be reported.

Q. Could dextran interfere with ross-matching?

A. Yes, it frequently does when the patient has had a large amount before blood for cross-match was drawn.

If any of you have problems which you would like to share with other readers, let us hear from you.

Woman Technologist Receives Biological Sciences Award

Mrs. Doris Whitney, Roselle, Ill., is the first woman to receive an award for "distinguished service to the technical and scientific community of Chicago."

Mrs. Whitney, program chairman of the Silver Anniversary Convention of the American Society of Medical Technologists, received her award in the field of biological sciences, at a dinner sponsored by the Chicago Technical Societies Council, a federation of 35 scientific, technical and engineering societies.

Death Rates Reach New Low in 1956

All-time low death rates were recorded in 1956 for tuberculosis, maternity, childhood diseases, suicide, and homicide, reports the Metropolitan Life Insurance Company on the basis of its industrial policyholders.

Polio death rate among those insured dropped to half that for 1955 —or .3 per 100,000.

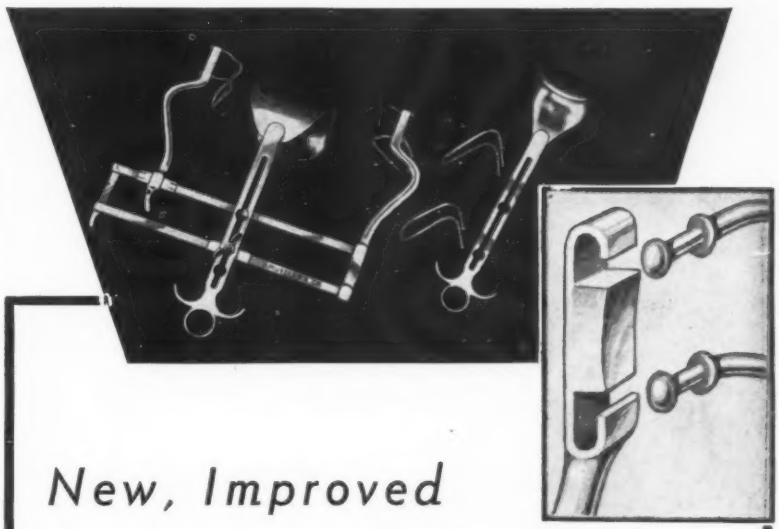
Cardiovascular-renal diseases accounted for a little over half the total deaths. Second were cancer and allied conditions. Accidents ranked third.

Tuberculosis mortality fell to the all time low of 7.1 per 100,000, a reduction of about 10 percent from 1955.

Death rate from communicable childhood diseases recorded a new low of .2 per 100,000 policyholders.

Deaths incidental to pregnancy and childbirth decreased to .9 per 100,000.

Accident fatalities increased .5 to 35.6 per 100,000, while suicide and homicide rates established new lows of 5.6 and 2.4 per 100,000, respectively.



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clinical notes

Antibiotic Mixtures

The administration of combinations of antibiotics is indicated only in a few highly selected conditions, writes Dowling in a special report to the AMA Council on Drugs, published in the *Journal of the AMA* 164:44-48 (May 4, 1957).

Such combinations have been advocated and used in other conditions in which they not only do no good but may actually be harmful, the author declares.

When combined therapy is indicated, the antibiotics are best given separately, he says, except in the case of mixtures for local application to the skin.

One reason given for the use of such mixtures is to obtain a synergistic action. In general, says the author, these mixtures do not produce a synergistic effect, and one antibiotic in a combination may even be antagonistic to the other under special circumstances. These mixtures can be used in a few diseases in which t value has been clinically proved, may occasionally be useful in a sp case outside of this group, he cludes.

To prevent the appearance of re ant strains of tubercle bacilli, c binations of two or more of the dr streptomycin, isoniazid, and am salicyclic acid are indicated, accord to Dowling, who warns that mixtu of these anti-infectives are not adv for the control of other bacteria.

Single antibiotics are often as sa factory as, or superior to, mixtu for the treatment of mixed infecti or for the disinfection of the intesti before abdominal operations, author states.

Polio Vaccine May Aid Against Herpes Simplex

Poliomyelitis vaccine, like small vaccine, may prevent recurrent sodes of herpes simplex, write Ad and Tschan in the *Journal of AMA* 164:205.

In a letter to the editor, they scribe the case of a laboratory te nician who, while using pipettes transferring tissue cultures, accid tally ingested and swallowed liqu cultures containing the HeLa cell i pregnated with all three types of po virus. Since ingesting the viruses, has had no recurrent episodes of h fever blisters.

The second patient, who had h recurrent herpes simplex six or sev times a year at the end of a comm cold, has had no recurrence since r ceiving two standard-dose injection of polio vaccine in the summer of 195

Spices for Ulcer Victims

Certain spices are not harmful to pa tients with active duodenal or gastri ulcers, according to Schneider DeLuca, and Gray, writing in th *American Journal of Gastroenterology* 26:722-32.

Cinnamon, allspice, mace, thyme, sage, paprika, and caraway seed, when administered with food, caused no discomfort and did not alter the healing time of the ulcer craters, the authors report.

Their conclusions were based on tests on 50 ulcer patients who re ceived .05 to .9 grams of spices in capsules three times a day over pe riods of two weeks to five months. Average testing period was 40 days.

Black pepper, mustard, chili pepper, cloves, and nutmeg resulted in dis comfort in several ulcer patients, and their use is not advocated.

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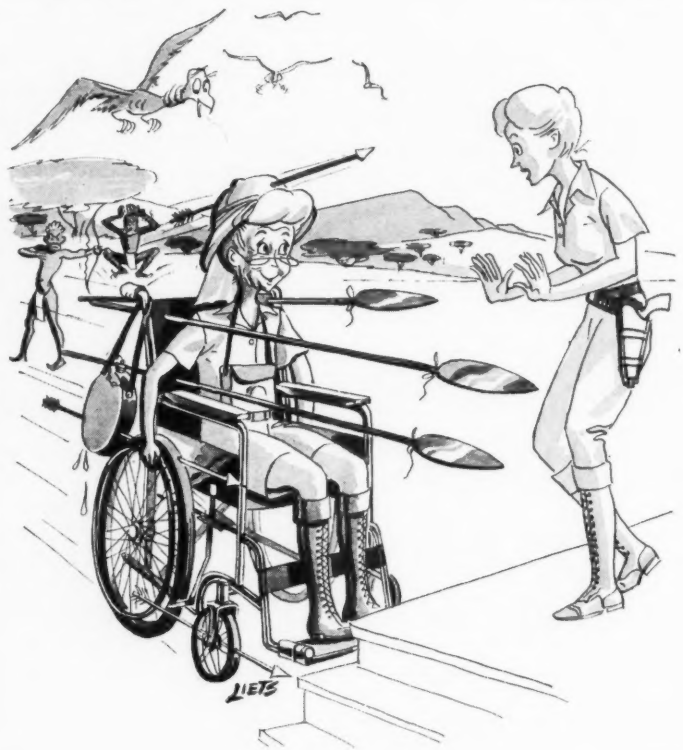

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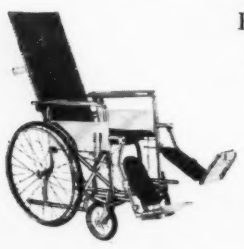

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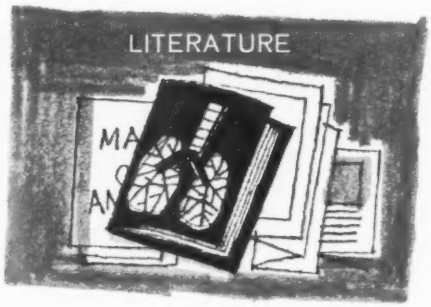

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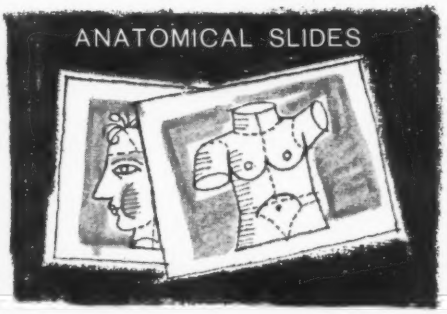

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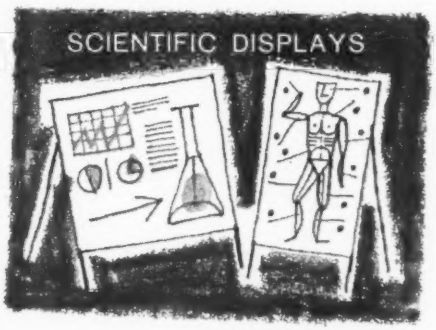

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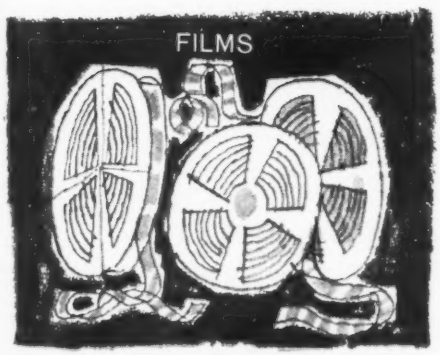

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Winthrop Laboratories has introduced its x-ray contrast agent Hypaque in special compound for use in angiocardiography.

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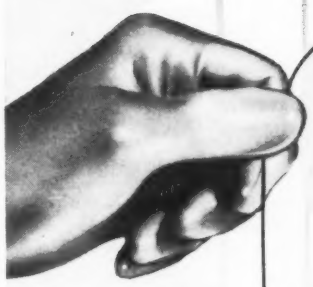

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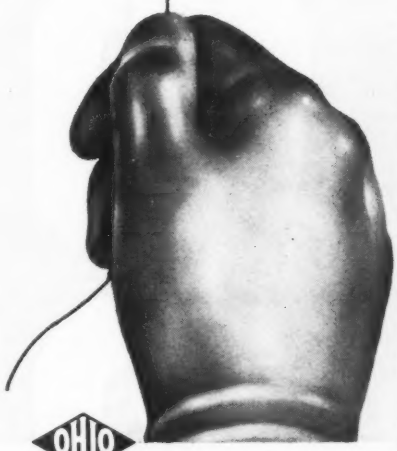

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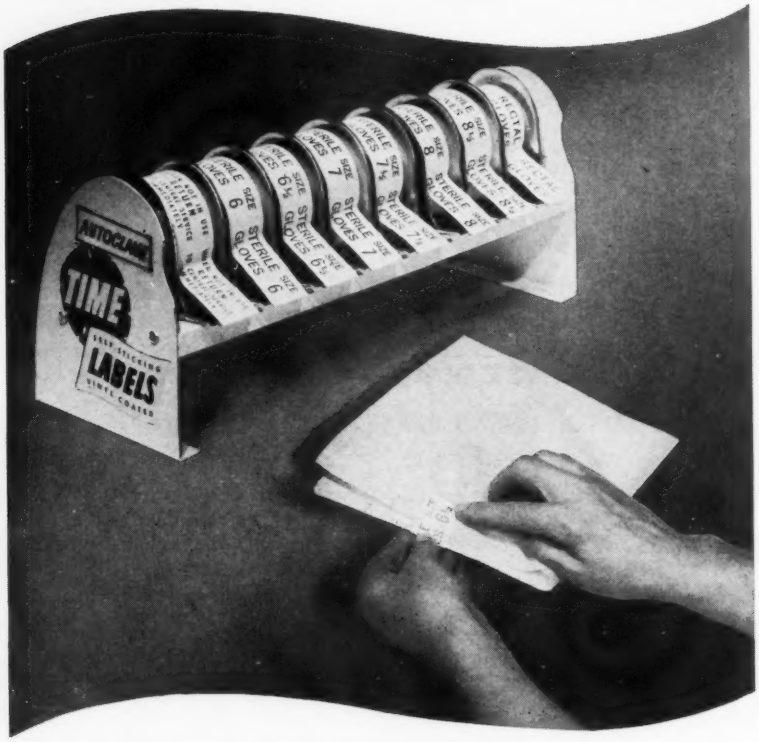

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IMFERON meets the need for a safe, effective agent when parenteral iron is preferable for patients with iron deficiency anemia who are resistant or intolerant to oral iron, those with depleted iron reserves and those who require rapid restoration of hemoglobin, *e.g.*, last trimester of pregnancy.

Previous parenteral iron preparations were unsatisfactory because of toxicity, pain on injection, or because they contained insufficient iron. IMFERON contains the equivalent of 5 per cent elemental iron. It is more stable than iron saccharate both *in vitro* and *in vivo* and does not precipitate in plasma over a wide pH range. It is isotonic with tissue fluids and has a pH of 5.2 to 6.0.[1] Utilization for hemoglobin formation is almost quantitative.

Precision Therapy with IMFERON: Before treating a patient with IMFERON, total iron requirement is calculated by formula or determined from a convenient dosage chart. Then appropriate amounts of IMFERON are injected daily or every other day, until the total calculated required amount is given.

Iron Deficiency Anemia of Infancy: IMFERON provides a convenient safe means for restoring hemoglobin levels and iron reserves in anemic infants. Excellent results were obtained by Gaisford and Jennison[2] with IMFERON in 100 iron-deficient infants. From a pretreatment average of 54.5 per cent, hemoglobin levels rose to 87 per cent 10 weeks after the start of therapy. Clinical improvement paralleled this response. Premature infants and surgical cases were similarly benefited. IMFERON gave "...all the advantages of transfusion or intravenous therapy without the disadvantages."[2] There were no side effects in any of the infants treated. Wallerstein[3] confirmed these results, furnishing evidence that IMFERON is well absorbed and appears in the bone marrow 12 to 24 hours after injection. Results are equal to those with intravenous saccharated iron oxide without the unpleasant side effects. Sturgeon[4] showed that the first year's iron requirements in infancy can be supplied with three injections of IMFERON.

Iron Deficiency Anemia of Pregnancy: Nausea precludes oral iron therapy in many anemic pregnant women. In those with severe anemia who are first seen late in pregnancy, prompt hemoglobin regeneration is unobtainable with oral iron. IMFERON produced prompt hemoglobin responses in anemia of pregnancy,[5,6] the results being similar to those obtained with intravenous saccharated iron oxide. Side effects were virtually absent with IMFERON.[5,6]

Resistant Hypochromic Anemia: Patients who do not respond to oral iron, those who cannot take oral iron and those with gastrointestinal pathology respond well to injections of IMFERON.[7-11] While oral iron is of little value in treating the anemia of rheumatoid arthritis, IMFERON is "...as beneficial as intravenous iron and easier to administer."[9]

Present Studies: Published reports and recent findings of clinical investigators confirm the effectiveness and safety of IMFERON for hemoglobin regeneration and creation of iron stores. More than 70 studies are now being completed in the United States. Reports stress prompt hemoglobin response, ease of administration and freedom from side effects. Clinicians desiring additional information should request Brochure No. NDA 17, IMFERON, Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin.

References: (1) Brown, E. B., and Moore, C. V., in Tocantins, L. M.: Progress in Hematology, New York, Grune & Stratton, Inc., 1956, vol. I, p. 25. (2) Gaisford, W., and Jennison, R. F.: Brit. M. J. 2:700 (Sept. 17) 1955. (3) Wallerstein, R. O.: J. Pediat. *49*:173, 1956. (4) Sturgeon, P.: Pediatrics *18*:267, 1956. (5) Jennison, R. F., and Ellis, H. R.: Lancet 2:1245 (Dec. 18) 1954. (6) Scott, J. M., and Govan, A. D. T.: Brit. M. J. 2:1257 (Nov. 27) 1954. (7) Grunberg, A., and Blair, J. L.: A.M.A. Arch. Int. Med. *96*:731, 1955. (8) Millard, J. B., and Barber, H. S.: Ann. Rheumat. Dis. *15*:51, 1956. (9) Baird, I. M., and Podmore, D. A.: Lancet 2:942 (Nov. 6) 1954. (10) Cappell, D. F.; Hutchinson, H. E.; Hendry, E. B., and Conway, H.: Brit. M. J. 2:1255 (Nov. 27) 1954. (11) Stevens, A. R.: A.M.A. Arch. Int. Med. *96*:550, 1956.

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